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ABSTRACT

This guide for condom availability programs provides information on how to build support for school-based condom availability programs. Chapter One explains why such a program is important. It examines behaviors and risks of sexually active adolescents, presents strategies for risk reduction, and discusses condom availability and use. Chapter Two discusses how to design a proposal, develop an action plan, and handle community reactions and media coverage. Chapter Three focuses on building community support, designing a community education campaign, working with the press, sponsoring public meetings, and responding to the opposition. Chapter Four discusses the condom availability program design team, how to design the program, staffing and training, student education and counseling, parent involvement, condom purchasing information, and budgets and financing. Chapter Five concentrates on program evaluation. Chapter Six focuses on legal issues, the school board's authority, parents' rights, and students' rights. It discusses such legal issues as condom failure and product liability, mandates for sexuality education, health services in the school, consent, and criminal liability. Pending cases on condom availability are summarized and legal principles supporting condom availability are reviewed. Chapter Seven presents case studies of three condom availability programs. Chapter Eight discusses school-based health center programs. Chapter Nine provides information on relevant organizations, books and reports, and articles. (NB)

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CONDOM AVAILABILITY IN SCHOOLS

A GUIDE FOR PROGRAMS

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CONDOM AVAILABILITY IN SCHOOLS
A GUIDE FOR PROGRAMS

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INTRODUCTION

The Guide for Condom Availability Programs provides information on how to build support for a new idea, school-based condom availability programs. It is important for program planners to remember that it will take time for the public to embrace this innovative response to problems resulting from sexual activity among adolescents.

Overcoming Denial

Adults are ambivalent and anxious about the idea of teenagers involved in sexual relationships – so anxious, in fact, that society overall has yet to acknowledge that young people are reaching sexual maturity at younger ages, at a time when we are asking them to postpone sexual activity until they complete more years of education. We acknowledge and are concerned that the electronic age gives teenagers information unimagined by many of us in our youth. Yet, overwhelmed, we collectively deny that adolescents experiment and take dangerous risks – including engaging in unprotected sexual intercourse.

People need accurate information to help them face these truths and work toward solutions. When adults read that over one million young women become pregnant each year and that one-in-four high school seniors will have a sexually transmitted disease before he or she graduates, the illusion that teenagers are abstinent quickly vanishes. When they learn of the increasing prevalence among young people of HIV, the deadly virus that causes AIDS, adults should reexamine policies that deny teenagers access to information about health and sexuality, and to contraceptives that help protect them from diseases.

That schools are an appropriate place to make condoms available is an even newer idea than comprehensive health education and services linked-to or based-in schools. Yet, at this writing, six major metropolitan areas make condoms available on a school- or district-wide basis. Many other school boards, alarmed by the prevalence in their communities of adolescent pregnancy and sexually transmitted diseases, are considering such plans.

Building Support

Some people need more time than others to consider new ideas. Some will never be convinced that the time has come for nationwide, school-based condom availability programs. However, no policy, educational or otherwise, ever has 100 percent of the public's support.

The Guide for Condom Availability Programs helps officials and community organizations gain public support for school-based condom availability by providing information on why such a program is important (*Chapter One: Making the Case*) and how to work with the community to gain its support and involvement (*Chapter Three: Working with the Community*). The Guide also helps officials in developing the policy (*Chapter Two: Developing Policy*) and in designing a condom availability program (*Chapter Four: Designing a Program*). To reinforce effective program design, *Chapter Five: Evaluation Strategies* discusses setting of goals and objectives as well as evaluation strategies for measuring effectiveness, and *Chapter Six: Legal Issues* presents legal considerations. *Chapters Seven: Three Case Studies, Eight: Condom Availability Through School-Based Health Centers and Nine: Resource List* provide concrete examples, experiences and information regarding the planning and implementation of condom availability programs nationwide.

The Center for Population Options(CPO) believes that young people can more effectively plan their futures and attain their life goals if they are healthy, both emotionally and physically. Comprehensive health services, including information and assistance to help them prevent too-early childbearing and infection with sexually transmitted diseases, including HIV, are vital to achieving that end. Access to age-appropriate information, family planning services and guidance in decision-making skills building are all necessary to help young people reach their potential. Condom availability programs can be part of a comprehensive plan to meet these needs and prepare young people for a healthy, productive future.

As adults we must set aside our anxieties and our denial and honestly confront the issues surrounding adolescent sexuality. We owe that to our children.

Margaret Pruitt Clark, Ph.D.
Executive Director
The Center for Population Options
April 1993

CITIES OR SCHOOLS WITH SCHOOL CONDOM AVAILABILITY PROGRAMS

Identified, as of 2/18/93

School-Based Health Centers Programs Implemented

Nationally, CPO estimates that over 50 school-based clinics health make condoms available to sexually active students, including:

Little Rock (AR)
Chicago (IL)
Baltimore (MD)
Portland (OR)
Minneapolis (MN)
Philadelphia (PA)
Cambridge (MA)
Los Angeles (CA)
Quincy (FL)
Miami (FL)
Dallas (TX)
New York City (NY)
Portsmouth (NH)
Culver City (CA)

School-wide or district-wide programs implemented

Falmouth (MA)
New York City (NY)
Philadelphia (PA)
Martha's Vineyard (MA)
Commerce City (CO)
Hatfield (MA)
Los Angeles (CA)
Washington (DC)
Santa Monica (CA)

Programs approved and being designed

Seattle (WA)
Newton (MA)
Brookline (MA)
Provincetown (MA)
Holden (MA)
Chelsea (MA)
Somerville (MA)
Sharon (MA)
Lincoln/Sudbury (MA)
San Francisco (CA)
Northboro (MA)
Northhampton (MA)
Amherst (MA)

Programs rejected

Chester (VT)
San Lorenzo Valley (CA)
Springfield (MA)
Randolph (MA)
Weymouth (MA)
Grafton (MA)
Laurence (MA)
Norwood (MA)
Everett (MA)
North Andover (MA)
Southbridge (MA)
Talbot County (MD)
Tamalpais HS, Marin Co. (CA)
Worcester (MA)
Dedham (MA)
Canton (MA)
Hopedale (MA)
Fitchburg (MA)
Swampscott (MA)
Grafton (MA)
Reading (MA)
Southwick-Tolland (MA)
Swansea (MA)
W. Springfield (MA)
Kennebunkport (ME)
North Shore (WA)
Palmer (MA)
Whitman (MA)
Lake Washington (WA)
Uxbridge (MA)
Winchester (MA)
New Bedford (MA)
West Newbury (MA)

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CHAPTER ONE

MAKING THE CASE

I. YOUTH AT RISK

Confronted with rising levels of adolescent pregnancy and the growing incidence among adolescents of sexually transmitted diseases (STDs), including the HIV virus that causes AIDS, most adults agree these threats to young people's health have reached crisis proportions. Strong interventions are needed to protect adolescents.

For many teens, schools are the primary source of accurate information about STDs; almost all states encourage or require HIV/AIDS prevention education in their schools. Comprehensive health and sexuality programs can also help teens delay initiation of sexual intercourse. But while education is critical for changing attitudes, it does not, alone, change the behaviors that put sexually active teens at risk of infection and unintended pregnancy. Teens also need to be provided the means to protect themselves and to be taught effective ways of discussing protection with their partners.

Many school personnel, public health officials and policymakers are suggesting that high schools make latex condoms available to sexually active students. They reason that schools are uniquely positioned to provide two-part health and sexuality programs that include education and access to barrier methods that protect against disease and unintended pregnancy.

Through these programs, those charged with educating adolescents hope to empower them to change their risk-taking, and sometimes life-threatening, sexual behavior.

A. Behaviors and Risks of Sexually Active Adolescents

Adolescents have a sense of omnipotence and invulnerability as they move toward independence. Their fearlessness can lead to dangerous behaviors, such as using drugs (including alcohol and tobacco) and having sex without contraception and/or protection.

The fact sheets at the end of this chapter document the scope and impact of risk-taking behavior among teens, and provide source citations for data in this chapter. These data comprise a compelling case for aggressive and effective intervention.

Large Numbers of Adolescents Engage in Sexual Activity. Surveys of adolescent sexual behavior indicate that young people are engaging in sexual intercourse at early ages. Seventy-seven percent of females and 86 percent of males are sexually active by age 20.

Sexually Active Adolescents Are At Risk for Unintended Pregnancy. Over one million teenage girls — one in 10 — become pregnant every year. Four out of 10 teenagers will become pregnant before turning 20. At least 82 percent of teen pregnancies are unintended. One out of four adolescents does not use an effective means of contraception.

Adolescents Are At Risk for STDs. For reasons related to their physiological development, adolescent women are more vulnerable to infection when exposed to STDs than are adult women. Rates of chlamydia, gonorrhea and syphilis for adolescent women are higher than for adult women. Over three million sexually active adolescents are infected with an STD annually, representing one-fifth of all STD cases in the nation. The American Medical Association estimates that one out of four teens will have an STD before high school graduation. The

estimate is even higher for youth who are not in school.[1] Left untreated, STDs can cause pelvic inflammatory disease, which is a cause of infertility and increases vulnerability to HIV.

Adolescents Are Also At Risk of Contracting HIV. Adolescents are just as vulnerable to contracting HIV as adults, and perhaps more so. Individuals already infected with an STD may have breakdowns of skin and mucosal barriers and thus are more vulnerable to HIV infection. Currently, almost 20 percent of people diagnosed with AIDS in the United States are in their 20s. Because the latency period between HIV infection and onset of symptoms is about 10 years, many were probably exposed to HIV as adolescents. From 1990 to 1992, the number of youth ages 13 to 24 who were diagnosed with AIDS increased by 77 percent.[2]

Making the case for a condom availability program will require *both* a command of national data *and* information about the local community. A *needs assessment* can be done to gather information about health and social problems affecting youth in the local community, what resources exist to address these problems and whether these resources are effective. The questionnaire designed and used by the Centers for Disease Control and Prevention (CDC) in their national Youth Risk Behavior Survey is available and may help communities gather local data. Additionally, local data on adolescent risk-taking behavior may already be available for communities that participate in CDC's annual survey. The CDC survey is particularly appropriate for doing needs assessments and surveillance. Chapter 5, "Needs Assessments and Evaluation Strategies," also provides suggestions for conducting a local needs assessment survey.

II. STRATEGIES FOR REDUCING THE RISK

A. Encouraging Abstinence

Only complete abstinence from risky sexual behaviors and judgement-impairing substances – such as alcohol and drugs – entirely eliminates the risk of pregnancy and STD infection. Comprehensive health education or HIV/AIDS prevention programs encourage young people to abstain from or delay sexual intercourse, and suggest substituting other forms of non-risky sexual activity.

Research has shown that some programs are effective in helping teens postpone intercourse. The "Postponing Sexual Involvement" (PSI) program developed at Grady Memorial Hospital in Atlanta, has been shown to increase the percentage of students who had not yet initiated intercourse by the end of the ninth grade from 61 percent (in the control group) to 76 percent (among program participants). By the end of eighth grade, students who did not participate in the program were as much as five times more likely to have initiated sexual intercourse than were PSI participants.[3] In contrast, the program demonstrated little, if any, impact on the behavior of teens who were already sexually active.

The Grady program uses the "social inoculation" model of outreach. This model assumes that young people engage in negative behaviors partly because of social influences and pressures, arising both generally and from their peers. Such programs use activities that help participants identify the origin of these pressures and develop skills to respond to them positively and effectively. Such programs also rely on peers – slightly older teens – to present information, lead group activities and discuss issues and problems.

Another program using social inoculation is "Reducing the Risk" (RTR), implemented and evaluated at 13 California high schools. RTR stresses that students should avoid unprotected intercourse – either through abstinence or contraception. RTR also encourages parent-child communication on subjects such as birth control and abstinence. The program significantly increased participants' knowledge of abstinence and contraception, and their communication about these topics with their parents. Participants who had not yet initiated intercourse indicated a significantly-reduced likelihood that they would have had intercourse 18 months later. Further, a survey of parents found broad support for RTR, as well as a belief that the program had had positive effects.[4]

"The main problem with condoms is that many people do not know how to use them."

C. Everett Koop, U.S. Surgeon General, 1987.[5]

Some adults believe teens should not be taught or shown methods of contraception and protection, and that sexuality education should focus exclusively on abstinence for unmarried adolescents. Numerous "abstinence-only" curricula are being promoted for use in schools that present opinion as fact, convey insufficient, inaccurate or biased information, rely on scare tactics, reinforce gender stereotypes and are insensitive to cultural and economic differences. These programs have not been adequately evaluated and should not be confused with the curricula mentioned here that have demonstrated a measure of success. (See Chapter 9 for a list of organizations that can provide assistance in selecting a sexuality education curriculum.)

There is little evidence that programs which promote abstinence alone are effective with adolescents who have already initiated sexual intercourse. Evaluations of even the most promising abstinence-based curricula reveal that substantial proportions of participants continue to engage in intercourse. These adolescents are at risk of pregnancy and STDs, including HIV.

Even the more successful abstinence-based curricula promote the delay of sexual activity but seldom prevent sexual intercourse until marriage. Most adolescents will eventually become sexually active. Therefore, all students must be taught the information and skills necessary to make healthy decisions and to accept personal responsibility.

B. Encouraging Condom Use

A majority of teens are sexually active. According to the CDC's 1990 Youth Risk Behavior Survey, 39.6 percent of ninth graders, 47.6 percent of tenth graders, 57.3 percent of eleventh graders and 71.9 percent of twelfth graders report they have had intercourse. Programs must help sexually active teens reduce the potential for negative consequences associated with unprotected intercourse.

Next to abstinence, latex condoms are the most effective method for reducing STDs and the sexual transmission of HIV infection. When properly used, latex condoms are also effective at reducing the risk of pregnancy. Promoting correct and consistent condom use by sexually active teens is an important strategy in curbing the national epidemics of HIV, other STDs and too-early childbearing.

The National Research Council, in its landmark 1987 report, *Risking the Future: Adolescent Sexuality, Pregnancy and Childbearing*, recommended "the development, implementation and evaluation of condom distribution programs."

An important U.S. National Health Promotion and Disease Prevention Objective is to increase the use of condoms at last intercource by sexually active females aged 15-19 from 25 percent in 1988 to 60 percent by the year 2000. For sexually active males ages 15-19, the year 2000 target is 75 percent.[5]

III. BARRIERS TO CONDOM ACCESS AND USE

Adolescents have a legal right to purchase condoms. Ensuring a minor's right to contraception does not, however, translate into easy access. Condoms may appear to be widely available, but a number of factors inhibit young people's ability to acquire and effectively use them.

Surveys have found that lack of availability is one of the most frequently cited reasons sexually active adolescents fail to use condoms. Furthermore, adolescents' desire for confidentiality often overshadows their concerns for health. While fear that others will learn they are sexually active does not keep teens from having intercourse, it does apparently inhibit them from purchasing condoms. Other factors, many of which are associated with low self-esteem, that teens perceive as barriers to regular condom use include:

- peer or partner pressure
- fear of loss of relationship
- fear of decreased sexual pleasure
- cultural expectations for gender-related behavior and roles
- denial of sexual activity
- alcohol and drugs which impair judgement, often contribute to risky behavior and failure to use condoms properly or at all
- anxiety about being seen by parents, friends or neighbors when purchasing condoms
- cost

A 1988 survey by members of the Center for Population Options (CPO) Teen Council examined the accessibility of contraception in drugstores and convenience stores in Washington, D.C. and found that:

- One-third of the stores kept condoms behind the counter, forcing teens to ask for them.
- Only 13 percent of the stores had signs that clearly marked where contraceptives were shelved.
- Adolescent girls asking for assistance encountered resistance or condemnation from store clerks 40 percent of the time.

For adolescents, these obstacles are significant barriers to contraceptive access. Evidence from other parts of the country suggests that D.C. is not unique.

Even in areas where health departments or family planning clinics provide condoms free of charge and without appointments, school or work obligations may combine with clinic schedules to make it difficult or impossible for adolescents to take advantage of these services. Rural youth, in particular, have concerns about transportation and privacy – being seen at the drug store or clinic by someone they or their parents know is more likely in a small town or rural community.

IV. FACTORS THAT INCREASE LATEX CONDOM USE

Logistical barriers to condom use can be addressed by making condoms widely and freely available; however, successful strategies to help teens use latex condoms properly and consistently must address *both* physical and psychological access. Psychological and emotional barriers to condom use are embedded in the culture and are harder to address. Access is enhanced with increased knowledge, social and physical skills, perception of personal risk and perceived peer and societal norms.

Among the factors specifically cited by teens that would tend to increase condom use are condoms' acceptability among peers and a perception that they are easy to use and permit spontaneity. Teens who believe condoms help prevent HIV transmission are also more likely to report consistent use.[7] Another survey of teenagers found that providing condoms free of cost and making them easy to obtain are crucial elements in increasing adolescent use.

To Increase Condom Use By Sexually Active Teens, Condoms Should be:

Available Confidentially

Affordable

Accessible

V. A PREVENTION STRATEGY THAT MAKES SENSE

Condoms are currently available to teens from a variety of sources: drugstores, family planning clinics, health clinics, supermarkets, convenience stores and vending machines. Making condoms available within schools does not introduce an otherwise unobtainable commodity to students. Rather, it expands the range of sources and facilitates teens' access to an important health aid. Adults understand that social endorsement by adults and society is a critical factor in normalizing condom use, and large majorities support giving teens access to condoms in school.

By making condoms available to students who choose to engage in sexual activity, schools let students know the community cares about their health and well-being. School programs reinforce that there are adults who will address adolescent sexual behavior, rather than deny it is a reality. While adults may prefer that young people refrain from sexual intercourse, it is important to help those teens who do not to avoid the negative consequences of HIV and other STDs, as well as unplanned pregnancy.

Condom availability programs eliminate some of the most significant barriers to condom use, including lack of access. By making condoms available in schools, caring adults can reach at-risk adolescents in a familiar and comfortable setting. Furthermore, programs can be designed specifically to reduce other barriers to condom use.

According to a 1988 Harris poll, 73 percent of adults favor making contraceptives available in schools. A 1991 Roper poll found that 64 percent of adults say condoms should be available in high schools. According to a Gallup poll released in August, 1992, adult support for condom availability has grown to 68 percent.[8] In April, 1992 a National Scholastic Survey also found that 81 percent of high school seniors felt condoms should be available; 78 percent felt condom availability programs do not encourage sexual activity. ■

Several studies have shown that sexually active teens are more likely to use condoms if they believe their peers are using them. Condom availability in schools promotes positive and open attitudes toward condoms, increasing the likelihood that teens not only will acquire the condoms they need to protect themselves, but will also use them.

Schools are in a unique position to help teens address issues that are clearly associated with inappropriate risk-taking behaviors. Schools can provide opportunities for students to increase self-esteem and to practice decision-making, negotiation and conflict-resolution skills. Thus, school condom availability programs supported by comprehensive life skills training are uniquely able to help students gain and practice the skills necessary for successful condom use.

Despite fears to the contrary, research clearly demonstrates that students in schools which make condoms and other contraceptives available through school-based health centers are no more likely to be sexually experienced than students in schools without these services available. In fact, at some schools with centers making contraception available, teens' mean age at first intercourse was older — and already sexually active teens' frequency of intercourse was lower — than at schools without contraception availability.[9]

VI. CONDOM AVAILABILITY AS PART OF A COMPREHENSIVE PROGRAM

It is important to remember that condom availability can be most effective only if it is part of a comprehensive health, sexuality education, HIV/AIDS and pregnancy prevention program. To affect adolescent behavior it is necessary to address teens' attitudes and knowledge of reproductive health issues, as well as their ability to access and use condoms and contraceptives effectively. Strategies must also seek to improve teens' capacity to abstain from or delay sexual intercourse. Outreach to at-risk teens, education, counseling and follow-up are all necessary components of a program. As a result, school condom availability programs typically involve collaborative efforts among schools, health agencies, youth-serving organizations and community members.

A surprising but important benefit of the debate over condom availability is the way the issue has engaged entire communities and increased public awareness. Schools are conducting surveys of teenagers to determine their level of risk-taking behavior. Students themselves are speaking out on the issue, sometimes being heard for the first time. Parents and community members are becoming more involved in the early stages of the debate and are helping to design these programs. Schools and communities are also taking the opportunity to evaluate whether the health education programs that already exist are comprehensive and teach decision-making skills as well as impart information.

The complex strands of cultural influence, socio-economic status, environment and individual personality that determine why people do the things they do are not easily disentangled. No single approach — sexuality education, condom availability or abstinence programs — can alone eliminate STDs and too-early childbearing among adolescents. These components combined can help teens to develop attitudes, skills and behavior patterns that will protect them from unnecessary risks throughout their lives.

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CHAPTER ONE ATTACHMENTS

A. The Facts: Condom Efficacy and Use Among Adolescents

B. The Facts: Adolescents and Condoms

C. The Facts: Adolescents, AIDS and HIV

D. The Facts: Adolescents and Sexually Transmitted Diseases

E. The Facts: Adolescent Sexuality, Pregnancy and Parenthood

F. The Facts: Adolescent Males and Teen Pregnancy

G. The Facts: Lesbian, Gay and Bisexual Youth: At Risk and Underserved

H. The Facts: Adolescent Substance Use and Sexual Risk-Taking Behavior

I. Excerpt from the 24th Annual Gallup/Phi Delta Kappa Poll of the Public's Attitudes Toward the Public Schools

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Condom Efficacy and Use Among Adolescents

Aside from abstinence from sexual intercourse, proper use of latex condoms is the best protection against the sexual transmission of diseases, including the human immunodeficiency virus (HIV) which causes AIDS. In 1987, U.S. Surgeon General C. Everett Koop stated, "The greatest problem with condoms is that many people do not know how to use them." [1] Adolescents, in particular, often lack access to information about the proper use of latex condoms. Failure rates cited for latex condoms are primarily due to human error which is preventable when users are educated, skilled and motivated to use condoms properly. Condoms and information on how to use them must be widely available and accessible to all, including our nation's youth, if the spread of HIV is to be contained.

Condom Use Increasing Among Adolescents, But Many Still Having Unprotected Intercourse

- As of September 1992, 10,182 cases of AIDS among young people (ages 13-24) were reported to the CDC. Nearly 20 percent (39,840) of persons reported with AIDS are 20 to 29 years old. Given the average ten-year latency period between HIV infection and onset of AIDS symptoms, many of these people were infected with HIV during their teenage years. [9]
- Among sexually active 17-19-year-old males living in metropolitan areas, reported rates of condom use at most recent intercourse more than doubled from 21 percent in 1979 to 58 percent in 1988. [7]
- Among sexually active 15 to 19-year-old females, 65 percent report using some form of contraception at first intercourse; almost half report using condoms at first intercourse. Among sexually active 15 to 19-year-old males, 55 percent report using condoms alone or with other contraceptive methods at first intercourse.[7,8]
- Teens are more likely to rely on condoms than are older individuals. Twenty-six percent of 15-19-year-old women at-risk for unintended pregnancy rely on condoms while only 13.1 percent of all American couples use condoms as their most common method of contraception.[3]
- Possible factors found to increase the likelihood of teen condom use include: feeling personally at risk for infection with HIV; believing condoms are effective in preventing HIV infection; having the skills to negotiate condom use with a partner; having talked to a physician about condoms; and perceiving peer approval of condom use.[20,21]

Condoms Are Very Effective When Used Correctly

- Studies have found that when used properly condoms fail as a contraceptive method 2 percent of the time.[3] In one British study, 17,856 acts of intercourse resulted in only one pregnancy.[22] However, with human error factored in, the percentage of women ages 15-44 who become pregnant in the first year of using a condom ranges between 9.5 [5] and 16 percent.[3]
- Research indicates that as with most contraceptive methods, condom failure rates are highest among 20-24-year-olds and lowest among 35-44-year-olds. 15-19-year-olds have slightly lower failure rates than 20-24-year-olds. [3]

Latex Condoms Help Protect Against HIV, Other STDs and Pregnancy and May Be More Effective Against Pregnancy When Used With Spermicide

- Laboratory tests have confirmed that latex used for condoms does not allow the passage of water, HIV or sperm. To illustrate the relative size of each substance, imagine the following: if a single sperm were the size of a freight train (in actuality, a sperm is 45,000 nanometers (nm)), HIV would be the size of an average man (100nm) and a water molecule would be the size of his small dog (20nm).[13]
- Laboratory tests indicate that latex condoms used with a contraceptive spermicide are effective in helping to prevent pregnancies.[2,11]

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- In laboratory testing, spermicide applied in the tip of a latex condom arrests up to 90 percent of active sperm within 30 seconds of contact; within two minutes, 98.5 percent of sperm present have stopped moving.[10] In actual use the extent of decreased risk as a result of using a spermicide has not been established.

Human Error Is the Primary Cause of Condom Failure

- Studies conclude that most latex condom failure is due to human errors including: incorrect or inconsistent use, damage caused by snags on fingernails or jewelry, improper lubrication and improper storage.[2, 7, 19] Additional reasons for latex condom failure include: using the condom after genital contact, failure to unroll the condom completely, insufficient lubrication, inadequate space for the ejaculate at the tip and withdrawing after loss of erection.[2]
- Low-income women are frequently cited as having higher contraceptive failure rates, which may be related to their limited access to health information, services and education.[19]
- To maintain durability of latex condoms, they must be stored in their original packaging in a cool, dry place. Leaving them in ultraviolet light weakens their strength 80-90 percent within 8 to 10 hours. Leaving them is wallets is also not recommended.[13]
- More than 80 percent of latex condom integrity is lost with the use of oil-based lubricants such as petroleum jelly, baby oil, shortening or other household oils. Oils break down the latex, increasing its susceptibility to tears and breakage in as little as 60 seconds. Appropriate lubricants are water-based and most contraceptive foams, gels and creams are also effective.[17, 18]
- According to one study of homosexual and bisexual men engaging in anal intercourse, one in 27 condoms broke due to physical stress on the condom and human error occuring before, during and after intercourse.[6]

High Standards Are Required in Testing Condom Efficacy

- Latex condoms made in the United States meet the voluntary industry standards developed by the American Society for Testing and Materials (ASTM) which govern acceptable size, elasticity/elongation, thickness/thinness, strength and leakage of condoms.
- The FDA's official acceptable quality level (AQL) specifies that if more than 4/1000 latex condoms fail the water leakage test, the entire lot must be recalled or withheld from sale. The average failure rate is 2.3/1000 among batches meeting the AQL.[4]
- The surface of FDA approved latex condoms are free of holes when inspected under a scanning electron microscope at 30,000 magnification power. Latex condoms remain free of pores even when stretched.[4, 12]
- Natural membrane, "skin" or "lambskin" condoms are not recommended for use in preventing the transmission of HIV and other STDs. Natural membrane condoms have pores up to 150 times larger than HIV, allowing for the possible transmission of HIV, herpes simplex and the hepatitis-B virus.[4, 14, 15, 16]

DIRECTIONS FOR CONDOM USE

Before Sexual Intercourse

1. Use a new latex condom every time you have oral, anal or vaginal intercourse - before foreplay and before the penis gets anywhere near any body opening (to avoid exposure to semen, vaginal fluid or blood that can carry infection).[23] Handle the condom gently. Check which way it unrolls (but do not unroll it yet).
2. Put the condom on before intercourse as soon as penis is hard. Be sure rolled-up ring is on the outside and make sure to leave space at the tip to hold semen after ejaculation.
3. Squeeze tip gently so no air is trapped inside. Hold tip while unrolling the condom - all the way down to the base of the penis. If the condom does not unroll, it is on incorrectly. Throw it away. Start over with a new one.

Warning

Some condoms contain the spermicide Nonoxynol-9, which helps prevent pregnancy and may help prevent HIV infection. A very small number of users are sensitive or allergic to latex rubber, spermicide, or lubricants. If either partner has any reaction to latex condoms or spermicide, stop use and see your doctor.

After Sexual Intercourse

1. Pull out slowly right after ejaculation, while penis is still hard, holding condom in place to avoid spilling semen.
2. Turn and move completely away from partner before letting go and removing condom.
3. Remove used condom and throw away properly. Do not flush condoms down the toilet. Use a new condom each time you have oral, anal or vaginal intercourse.[23]

Tips for Success

- Never let a condom touch oil of any kind - petroleum jelly, baby oil, mineral oil or vegetable oil - because oil deteriorates latex or rubber. Baby powder also damages latex.
- For lubrication, always use something water-based, such as personal or surgical jelly.
- For extra safety, pull out the penis with condom still on before ejaculation.
- Keep new condoms in their packs in a cool dry place.
- If a new condom feels sticky or stiff or looks damaged in any way, throw it out and use a fresh one.
- Always have several condoms available.

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ADOLESCENTS AND CONDOMS

Recent data suggest that more teenagers are becoming sexually active at younger ages. These teenagers are at risk of becoming pregnant/making someone pregnant and contracting/spreading sexually transmitted diseases (STDs), including HIV which causes AIDS. Condoms are particularly well-suited as a contraceptive method for adolescents and, aside from abstinence, properly used latex condoms are the most effective method for preventing infection with HIV and other STDs. There is considerable evidence that teenagers are knowledgeable about the threat of HIV and about the means to protect themselves, yet many sexually active teens still do not use condoms consistently.

Sexual Activity Among Teenagers Is Increasing

- By age 20, 75 percent of females and 86 percent of males are sexually active.[1,4]
- The percentage of never-married 15- to 19-year-old females reporting sexual activity rose from 42 percent in 1982 to 51.5 percent in 1988, the most recent year for which data are available.[1] In 1988, 60 percent of 15 to 19-year-old never-married males reported sexual activity.[4]
- 26 percent of females report having had sexual intercourse by age 15.[1] 26 percent of white males, 33 percent of Hispanic males and 69 percent of black males report having had sex by age 15.[4]

Rates Of Contraceptive Use Among Sexually Active Adolescents Are Also Rising, Mostly As A Result Of Increased Condom Use[2,3,4]

- Among sexually active 17- to 19-year old males living in metropolitan areas, reported rates of condom use at most recent intercourse more than doubled from 21 percent in 1979 to 52 percent in 1988.[4]
- Among sexually active 15- to 19-year-old females, only 65 percent report using any form of contraception at first intercourse; almost half report using condoms at first intercourse.[3] Among sexually active 15- to 19-year-old males, 55 percent report using condoms alone or with other contraceptive methods at first intercourse.[4]
- One study of sexually active teens found that 31 percent reported always using condoms, 32 percent sometimes and 37 percent reported never using condoms.[6]

Despite Increased Contraceptive Use, Many Teenagers Remain At Risk Of Pregnancy

- 21 percent of sexually active 15- to 19-year-old females use no method of contraception. An additional 8.4 percent use withdrawal as their contraceptive method.[3] Three-quarters of all unintended adolescent pregnancies occur to teenagers who do not use contraception.[11]
- An estimated 43 percent of all adolescent girls will become pregnant at least once before age 20.[10] Among 15- to 19-year-olds in the U.S., the pregnancy rate is 123 per thousand.[8]
- More than one million teenage girls - or one in 10 - become pregnant every year.[9] Almost 473,000 teenagers gave birth in 1987; another 407,000 are estimated to have had legal abortions.[10]

One Out Of Four Teens Becomes Infected with a Sexually Transmitted Disease (STD) by Age 21 [12]

- Two and a half million adolescents are infected with an STD annually.[13]
- From 1960 to 1988 the prevalence of gonorrhea among 15- to 19-year-olds increased by 170 percent, more than quadruple the rate of increase among 20- to 24-year-olds.[14]
- The prevalence of chlamydia among adolescent women is estimated at 8 to 40 percent. Whether due to sociobehavioral factors or biological susceptibility, teenagers are at greater risk of chlamydial infection than older women.[16]

- The risk of acquiring pelvic inflammatory disease (PID), which is associated with chronic pelvic pain, infertility and increased risk of ectopic pregnancy, is estimated at one in eight for sexually active 15-year-olds, compared with one in 80 for sexually active women 24 years of age and older.[17]
- One study found that 38 percent of sexually active teens are infected with the human papilloma virus (HPV) which causes genital warts and is associated with a higher risk of cancer in women.[18]
- Over one-fifth of people with AIDS are in their 20s; because the latency period between HIV infection and onset of symptoms is about 10 years, most of these people probably became infected as adolescents.[16]
- Reported cases of AIDS among adolescents increased 29 percent between July 1990 and July 1991.[31] In 1986 AIDS was the 7th leading cause of death among 15- to 24-year-olds; in 1987 it climbed to the 6th leading cause.[19]

Almost Half of All Teens Do Not Receive HIV/AIDS Education at School

- A 1989 survey found that only 54 percent of teenagers reported receiving HIV/AIDS education in school.[25]
- Every state but Louisiana, Massachusetts, Mississippi and Wyoming requires or encourages the provision of AIDS education in public schools. Twenty-seven states and the District of Columbia have produced AIDS curricula.[26]
- Nineteen state curricula include instruction on condom use to prevent the transmission of STDs, including HIV.[26]
- Of AIDS curricula used by large school districts around the country, 86 percent discuss condoms as a means of preventing HIV infectionbut only 44 percent of these curricula include information about clinics and physicians that can provide contraceptives.[26]
- A recent survey of sexuality education teachers in public schools found that nine out of 10 cover such topics as how HIV and other STDs are transmitted, sexual decision-making, abstinence and contraceptive methods; 77 percent include instruction on how to use a condom, but only about half provide information on where students can obtain contraceptives.[27]

Concerns About Confidentiality, Cost and Access Are Among the Reasons Sexually Active Teenagers Do Not Use Contraception[7,21,22,23]

- A study of adolescents' attitudes towards condoms found that the beliefs that condoms are popular with peers, permit spontaneityand are easy to use are positively associated with the intention to use them.[5]
- A 1988 survey of Washington, D.C. drugstores and convenience stores found that in more than one-third of the stores, condoms were kept behind the counter. Only 13 percent of the stores had signs that clearly marked where contraceptives were shelved. Adolescent girls asking for help encountered resistance or condemnation from store clerks 40 percent of the time.[24]
- 93 percent of the adolescents in one survey knew that condoms prevent the spread of STDs, however, belief in the preventive benefits of condoms was not associated with increased motivation to use them.[5]

Two Out of Three Adults Believe Condoms Should Be Available in Schools

- A 1991 Roper poll found that 64 percent of adults say condoms should be available in high schools; 47 percent favor making condoms available in junior high schools.[20]
- An in-depth study of school-based clinics which dispense birth control found that making contraceptives available in school does not promote sexual activity.[21]
- A poll conducted between March and June, 1987, determined that 83 percent of parents, 89 percent of adolescent females and 92 percent of adolescent males approved of condom advertisements on television.[28]

Compiled by Elizabeth Armstrong, October 1991

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The Facts

ADOLESCENTS, AIDS AND HIV

AIDS is not highly visible in the adolescent population — less than 1 percent of the national AIDS cases reported to the Centers for Disease Control (CDC) are among teenagers. And yet, the formative period of adolescence often involves participation in risk-taking behaviors. This factor, combined with the likelihood that one-fifth of all people with AIDS (adults ages 20-29) were probably infected in their teenage years, has prompted the Public Health Service to make teenagers a central target of HIV prevention education. During the last decade, teens reported higher levels of sexual activity at earlier ages, experienced more than one million pregnancies a year, and suffered from persistently high rates of sexually transmitted diseases. To reduce the incidence of AIDS in the future, policies and programs must address adolescent decision-making regarding sexual activity and substance abuse. This effort will also afford an opportunity to confront the more visible crises of unwanted teen pregnancy and STD infection.

The First Decade of the Epidemic: Trends and Forecasts

- An estimated one million people in the United States are infected with HIV[1]; this number represents approximately one in 100 adult males and one in 600 adult females.[2]
- In 1987, the Centers for Disease Control determined that AIDS was the 15th leading cause of all U.S. deaths. Among men aged 25-44, AIDS became the second leading cause of death in 1989 and is estimated to become the fifth leading cause of death among women in the same age group in 1991.[3]
- Between 1981 and May 1991, more than 179,000 cases of AIDS and over 113,000 AIDS-related deaths were reported to the CDC. The Public Health Service predicts that a cumulative total of 400,000 diagnosed cases of AIDS and 290,000 AIDS-related deaths will be reported to the CDC by the end of 1993.[1]
- Current calculations of AIDS-related deaths are believed to be inaccurate due to underreporting and underdiagnosis. Because many clinical manifestations are not reportable under the current CDC surveillance definition of AIDS, only three-fourths of deaths attributable to HIV infection are believed to be reported.[1]

HIV Infection Among Teenagers

- As of May 31, 1991, 691 cases of AIDS among teenagers (ages 13-19) were reported to the CDC. However, more than 20 percent (35,635) of persons reported with AIDS are in their 20's. Given the average ten year period between infection and onset of symptoms, the majority of these people were probably infected with HIV during their teenage years.[4]
- Among teenagers who applied for military service between 1985 and 1989, three out of every 10,000 tested positive for HIV. Among black teens, the infection rate was one in 1,000.[5]
- In an HIV seroprevalence survey conducted at 19 universities throughout the United States, thirty (0.2 percent) of the 16,861 students, or one in 500, tested positive for HIV.[6]
- In a study conducted by a shelter serving runaway and homeless youth, 142 youth in the study — more than 5 percent — were infected with HIV.[7]
- A greater percentage of adolescents than adults with AIDS are female (26 percent vs. 10 percent), are black and Hispanic (56 percent vs. 44 percent) and were infected with HIV through heterosexual contact (14 percent vs. 5 percent).[4]

Sexual Activity, Drug Use, and STDs

- Adolescent women are initiating sexual intercourse at an increasingly early age. Between 1970 and 1988, the proportion of adolescent women ages 15 - 19 who reported having had premarital sexual intercourse increased from 28.6 percent to 51.5 percent. The largest increase occurred among those 15 years of age (from 4.6 percent to 25.6 percent).[8]

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- Adolescents who initiate sexual intercourse at younger ages are more likely to have multiple partners, thus increasing their chances of becoming infected with STDs, including HIV. In 1988, 75 percent of 15 - 24 year olds who had initiated intercourse before age 15 reported having had two or more partners, and 45 percent reported having had four or more partners. Only 20 percent of women who had become sexually active after age 19 reported having more than one partner and 1 percent reported four or more partners.[8]
- Several studies have shown that sexually active teens are much less likely to use condoms after drinking alcohol or using drugs.[9,10] Among inner-city youth who were highly informed about HIV transmission, occasional alcohol and marijuana use were considered to be strong predictors of high-risk sexual activity.[10]
- The use of crack cocaine is associated with high levels of sexual activity and risk-taking. A study of female crack users found that they reported twice as many sexual partners per month as non-users. One-third of black adolescent male crack users in another study reported ten or more sexual partners in the last year.[11]
- While most age groups experienced a decline in rates of gonorrhea between 1975 and 1989, rates actually increased among adolescents, with the sharpest increase appearing in black teenagers. In 1989, approximately 175,000 cases of gonorrhea infection were reported among teens.[12]
- Sexually active adolescents who suffer from genital ulcers associated with syphilis or genital herpes may be at greater risk of acquiring HIV as several studies have shown that genital ulcers facilitate transmission of the virus.[13] During the last two decades, reports of symptomatic genital herpes among adolescents increased from an estimated 15,000 in 1966 to 125,000 in 1989.[12]

Homelessness, Poverty, and Abuse May Increase Adolescent Exposure to HIV

- Approximately one million youth run away from their homes each year due to family conflicts, violence, and abuse.[14]
- In a shelter serving runaway and homeless youth in New York City, almost all youth (91 percent) reported being sexually active, with an average of nearly 3 sexual partners a week. Thirty-eight percent said they used crack and 29 percent admitted to having exchanged sex for food, money, shelter or drugs.[15]
- Nationally, approximately one in four girls and one in six boys are sexually assaulted before the age of 18. Studies indicate that a history of sexual abuse is associated with behavioral outcomes that place an individual at high risk for exposure to HIV — such as prostitution, teenage pregnancy and having multiple sexual partners.[16]

Current Education Efforts and Future Directions

- By January 1991, 33 states and the District of Columbia required that all school districts provide some form of AIDS education.[17]
- Although the vast majority of teenagers know the basic facts about HIV transmission, many continue to have misconceptions about the disease. In one study, 12 percent of high school students thought that birth control pills provided some protection against HIV; 23 percent thought they could tell whether a person was infected by looking at this person, and 55 percent thought insect bites could transmit HIV.[18]
- National studies suggest that AIDS awareness is partly responsible for an increase in condom use among sexually active teens. In one study, condom use increased among sexually active women, ages 15-19, from 21 percent in 1982 to 33 percent in 1988.[19] Another study showed that between 1979 and 1988, reported use of condoms at last intercourse among 17-19 year old males living in metropolitan areas more than doubled—from 21 percent to 57 percent.[20]
- Despite high levels of knowledge about HIV, sexually active adolescents are not likely to adjust their behavior based on factual information alone. Sexually active teens are more likely to use condoms consistently if they also feel personally at risk; believe condoms are effective in preventing HIV infection; have the skills to negotiate condom use with a partner; have talked to a physician about condoms, and perceive peer approval of condom use.[9,21]

Compiled by Christina Biddle, July 1991

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ADOLESCENTS AND SEXUALLY TRANSMITTED DISEASES

The rapid growth of HIV infection raises significant concerns about the overall reproductive health status of today's adolescents. Teenagers, because of their risk-taking behaviors, are at risk of HIV infection, a threat which is further complicated by the dramatic leap in other sexually transmitted diseases (STDs). While adolescents experience higher rates of STDs than any other age group, they are least likely to obtain care. When left undiagnosed and untreated, STDs exact a high cost in pelvic inflammatory disease, infertility, ectopic pregnancy, and cervical cancer. They also can facilitate transmission of HIV.

Sexually Transmitted Diseases and HIV Infection

- Every year 2.5 million U.S. teenagers are infected with an STD; this number represents approximately one out of every six sexually active teens and one-fifth of the national STD cases.[1]
- Over one-fifth of people with AIDS are in their 20's.[2] Because the latency period between HIV infection and onset of symptoms is about ten years, most of these people probably became infected with HIV as teenagers.
- As of July 30, 1990, 558 cases of AIDS among teenagers were reported to the Centers for Disease Control. Of the teenagers infected, 44 percent are white, 36 percent are black, 18 percent are Hispanic, and 2 percent are of other races.[2]
- While the rate of syphilis infection declined steadily between 1982 and 1986, it increased dramatically -- by 46 percent-- over the past several years, reaching a rate of 16.6 per 100,000, the highest level in forty years.[3]
- Approximately 1-2 million cases of gonorrhea are believed to occur each year. While rates of gonorrhea have steadily declined, many new penicillin-resistant strains have emerged.[4] Overall rates among adolescents have declined more slowly than any other age group, and have actually increased among black adolescents.[1]
- Among sexually active women, rates of gonorrhea and syphilis infection are highest among adolescents and drop rapidly with increasing age.[5]
- Nearly 1 million cases of human papillomavirus (HPV) are believed to occur each year.[1] One study found that 38 percent of sexually active teens examined were infected with HPV.[6]
- Chlamydia represents the most prevalent STD in the United States infecting an estimated 4 million people each year.[1] Adolescents have the highest rate of chlamydial infection and associated complications, such as pelvic inflammatory disease, ectopic pregnancy, and infertility.[7]

Behavioral Risk Factors

- Adolescents who initiate sexual intercourse at younger ages are more likely to have multiple partners in their adolescent years, thus increasing their chances of acquiring a STD, including HIV.[8]
- The average age of first sexual intercourse is 16.2 for females and 15.7 for males.[9] From 1982 to 1988, the percentage of 15- to 19-year-old girls who had ever had premarital sexual intercourse increased from 43 percent to 51 percent.[10]
- In metropolitan areas, in 1979, 66 percent of adolescent males ages 17-19 reported that they were sexually active. This number increased to 76 percent in 1988.[11] Reported use of condoms at last intercourse also rose from 21 percent in 1979 to nearly 58 percent in 1988.
- While adolescents exhibit a high level of knowledge about modes of HIV transmission,[12] few sexually active teens change their behavior based on factual information alone. In one 1988 study conducted in Massachusetts where teen

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knowledge of HIV is reported to be high, two-thirds of sexually active teens, ages 16-19, reported recent sexual intercourse without the use of condoms.[13]

- Sexually active teens are more likely to use condoms consistently if, in addition to knowing the facts about HIV and STDs, they feel personally at risk; believe condoms are effective in preventing HIV infection; perceive few barriers to their use; consider them to be popular among their peers, and have the skills to negotiate condom use with a partner.[14,15,8]
- Drug and alcohol abuse are major co-factors in the HIV and STD epidemics. While IV drug use provides a direct route for HIV transmission, non-injection drugs and alcohol can compromise judgment, reducing the likelihood that a young person will make appropriate decisions about avoiding HIV.
- HIV infection may be present for up to 10 years before showing symptoms, nonetheless, teenagers often believe that they are capable of identifying someone with HIV infection.[8]
- Many teenagers with an STD are asymptomatic or do not recognize their symptoms,[16] thereby leading to secondary complications, including pelvic inflammatory disease, ectopic pregnancy, cervical cancer, and infertility.
- Adolescents are often reluctant to seek regular reproductive health care or treatment for an STD. Most adolescents learn that they have a sexually transmitted disease only after they have sought health care for some other reason, most often contraception or prenatal care.[17] On average, girls who are sexually active wait 11.5 months between initiating intercourse and making their first visit to a family planning clinic.[18]
- Once diagnosed with an STD, only half of all teenagers will agree to full treatment.[19] This low compliance with treatment regimens has been partly attributed to adolescent concern about confidentiality.[20]

Medical Risk Factors and Implications

- Sexually active adolescents who suffer from genital ulcers associated with syphilis or genital herpes may be at greater risk of acquiring HIV. Several studies have shown that genital ulcers facilitate transmission of HIV.[21]
- Adolescent females suffer disproportionately from the more severe conditions of STDs. This fact is attributed, in part, to their developing cervical anatomy which predisposes them to STDs and subsequent infections.[20]
- Young women who initiate intercourse at an early age face the greatest risk of developing cervical cancer, usually discovered 6-20 years after first coitus.[22]
- Each year, approximately one million women experience an episode of pelvic inflammatory disease (PID), 16-20 percent of whom are adolescents.[20] Adolescent females with multiple partners have the greatest risk of developing acute PID. Among sexually active women, adolescents face a one-in-eight chance of developing PID compared with a one-in-eighty chance among 24-year-old women.[23]
- An estimated 60,000 women each year become infertile as a result of PID.[23] Women ages 15-24 who have experienced an episode of PID face a 9.4 -52 percent risk of becoming infertile, depending upon the number of repeat infections.

Access to Education and Services

- Twenty-eight states and the District of Columbia require some form of HIV education for students.[24] While the majority of school districts provide some form of HIV education, most do not require it at every grade level, nor do they guarantee adequate training for all teachers. One study found that only 5 percent of the surveyed districts require HIV education at all levels and one-fifth of teachers nationwide had not been trained by the end of the 1988-89 school year.[25]
- All 50 states permit a minor to consent to treatment for an STD, but only five states specifically authorize minors to give consent to HIV testing.[26]
- Only 10 percent of primary care physicians surveyed in 1988 ask their patients questions that might reveal their STD status,[27] and in 1985, almost half of U.S. medical schools offered no clinical curricula on STDs.[3]

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ADOLESCENT SEXUALITY, PREGNANCY AND PARENTHOOD

The United States bears the unfortunate distinction of having the highest adolescent pregnancy, abortion and birth rates in the developed world. According to recent estimates, 43 percent of all adolescent girls will experience at least one pregnancy before they reach age twenty.[1] Too-early childbearing exposes an adolescent and her baby to health risks, truncated education, and poverty. Teenage childbearing is also expensive. In 1988 alone, U.S. taxpayers spent almost $20 billion to support families started when the mother was a teenager.

Teens Do Have Sex, Don't Use Contraceptives

- The average age of first sexual intercourse is 16.2 for girls and 15.7 for boys.[2] One study found that among inner-city black males the average age of first intercourse is 11.8.[3]
- Approximately one-fourth of 15-year-old girls and one-third of 15-year-old boys have had sexual intercourse.[4,5] Among all adolescents, 77 percent of females and 86 percent of males are sexually active by age 20.[5,6]
- From 1982 to 1988, the percentage of 15- to 19-year-old girls who had ever had premarital sexual intercourse increased from 43 percent to 51 percent.[7]
- On average, girls who are sexually active wait 11.5 months between initiating intercourse and making their first visit to a family planning clinic. 36 percent visit the clinic only because they suspect they are pregnant.[8]
- More than one-fifth of all initial premarital pregnancies occur in the first month after the initiation of sexual intercourse and half occur within the first six months.[9]
- 41 percent of the 15- to 19-year-old girls surveyed in a recent study reported not using contraception at first intercourse, while 29 percent failed to use contraception at last intercourse.[4]
- 75 percent of all unintended teenage pregnancies occur to adolescents who do not use contraception.[10]
- While latex condoms used consistently and correctly are not 100 percent effective in protecting against sexually transmitted diseases (including the human immunodeficiency virus (HIV), which causes AIDS), they provide the best protection available for people engaging in sexual intercourse. According to one survey, only about one-third of sexually active teenagers report using condoms more often than any other method of contraception.[11]

There Are More Than One Million Adolescent Pregnancies Each Year

- More than one million teenage girls become pregnant in the United States each year. That's one out of every ten girls under the age of 20.[12]
- Among all teens ages 15 to 19, the pregnancy rate per thousand girls was 110 in 1985, up from 95 per thousand in 1972.[13] The pregnancy rate among sexually active teens, however, has fallen from 264 per thousand in 1970 to 233 per thousand in 1984, probably due to increased contraceptive use.[1]

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- There were 472,623 births to teenagers in 1987. Two percent of these were to teens ages 14 and younger, 37 percent were to 15- to 17-year-olds, and 61 percent were to 18- to 19-year-olds.[14]
- Approximately 13 percent of all teenage pregnancies end in miscarriages or stillbirths.[13]
- 42 percent of pregnancies to both white and non-white 15- to 19-year-olds end in abortion, as do 46 percent of pregnancies to teens 14 and younger.[12] Teenagers account for about one-quarter of the total number of abortions performed in the U.S.[16]
- Only 4 percent of unmarried teen mothers put their babies up for adoption.[17]
- 30 percent of teenagers who first give birth at age 16 or younger have a second child within 2 years, compared with 14 percent of women who wait at least until age 22 to have their first child.[18]
- 18 percent of teenagers who gave birth in 1987 gave birth to their second child; 3 percent gave birth to their third.[14]
- Other developed countries have lower teen pregnancy, birth and abortion rates than the U.S. In 1981, the U.S. pregnancy rate was 96 per thousand girls ages 15 to 19. The comparable rates were 45 in England and Wales, 43 in France, 44 in Canada, 35 in Sweden, and 14 in the Netherlands. In the United States, the teenage abortion rate alone is as high as, or higher than, the teenage pregnancy rate in any of these countries.[19]

Pregnant and Parenting Teens Face Health Risks, Academic Failure, and Poverty

- During pregnancy, teenagers are at a much higher risk of suffering from serious medical complications, including anemia, pregnancy–induced hypertension (toxemia), cervical trauma, and premature delivery, than older women.[20]
- The maternal mortality rate for mothers under age 15 is 60 percent greater than for women in their 20's.[20]
- Although prenatal care would help teens to have pregnancy outcomes comparable to those of women in their 20's, teens delay seeking prenatal care, if they seek it at all.[21] 46 percent of teenage mothers do not receive prenatal care during their first trimester, 9 percent do not receive care until their third trimester, and 4 percent do not receive prenatal care at all.[14]
- Infants whose mothers received no prenatal care are 40 times more likely to die during the neonatal stage than infants born to women who received adequate prenatal care.[22]
- Teenage girls who give birth are less likely to ever complete a high school education than their non-parenting peers. At least 40,000 teenage girls drop out of school each year because of pregnancy.[23]
- Only 39 percent of teen fathers receive high school certification by age 20, compared with 86 percent of males who postpone parenting.[24]
- 64 percent of births to teenagers in 1987 were to unmarried teens.[14] Among all women, only 18 percent of unmarried mothers have court orders to receive child support from their children's fathers compared with 74 percent of mothers who have been married.[25]
- At least 60 percent of teenage marriages end in divorce within the first five years.[26]
- Teenage mothers earn about half the lifetime income of women who first give birth in their 20's.[23]
- 70 percent of families maintained by women under age 25 were living below the poverty level in 1987.[27]
- In 1988 alone, the U.S. spent $19.83 billion on Aid to Families with Dependent Children (AFDC), Medicaid and Food Stamp payments to families started when the mother was a teenager.[28] Over half of AFDC payments go to support families begun when the mother was a teenager.[29]

Compiled by Elizabeth Armstrong and Alisa Pascale, May 1990.

The Facts

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ADOLESCENT MALES AND TEEN PREGNANCY

Although the average age of first intercourse in the U.S. is under 16 for boys, fewer than a third of all boys have received any sexuality education in school by that age. If we are to address the dilemma of teen pregnancy, we cannot neglect one of its crucial actors—the adolescent male. Far too often, both programs and research on adolescent pregnancy prevention focus solely on young women. Understanding young men and their behaviors, experiences and attitudes regarding sexuality and parenthood is central to understanding the causes of teen pregnancy, and to providing all teenagers with the information they need to make responsible sexual decisions.

Four Out of Five Boys Are Sexually Active by Age 19

- The average age of first intercourse for males is 15.7 years; for females it is 16.2. For white males, it is 15.9 years and for black males, 14.4.[1]
- A 1981 study found the average age of first sexual intercourse for urban black males to be 11.8 years.[2]
- By age 15, one out of three boys (33 percent) has experienced sexual intercourse. By age 16, one-half of all adolescent males have become sexually active; by age 19, 86 percent of never-married males have had sexual intercourse.[3]

Boys Less Likely to Receive Sex Education Than Girls

- While 60 percent of teenage girls report having received sexuality education in school by age 19, only 52 percent of boys have. Only 8 percent of boys receive sexuality education by age 13.[4]
- Among males who initiate sexual activity at age 15, only 1 out of 4 has taken a sexuality education course before first experiencing sexual intercourse.[4]
- Only 18 percent of young men report having first learned about sex from a parent, compared with 34 percent of young women.[5]
- Male friends, professionals such as doctors or teachers, and female friends were identified as the most common sources of information about sexuality in one survey of teenage boys.[6]

Contraceptive Use by Adolescent Males

- 62 percent of 15- to 19-year-old males report practicing contraception at first intercourse, even if first intercourse had not been planned. Among teenage males who do use contraception at first intercourse, 55 percent report using a condom.[3]
- Among all teens practicing birth control at first intercourse, planned or unplanned, a male method of contraception (condom or withdrawal) is most commonly used.[1]
- 77 percent of sexually active male teens report that they practiced contraception at last intercourse; 57 percent report using a condom; 20 percent report that their partners used an effective female method such as the pill, diaphragm, IUD, sponge, or spermicidal foam or jelly.[7]
- 47 percent of sexually active adolescent males identify condoms as the method of contraception they use most frequently.[7]
- A 1985 survey of male adolescents found that boys choose to use condoms because they are perceived as: a) easy to use; b) popular with peers; c) enhancing male responsibility; and/or d) enabling one to have sex on the spur of the moment. The ability of condoms to protect simultaneously against pregnancy and sexually transmitted diseases is not a significant factor in the boys' intentions to use them.[8]

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Boys' Attitudes Towards Sexuality and Parenthood

- Only 25 percent of males report having planned their first sexual intercourse.[1]
- 80 percent of sexually active teen males, when asked the ideal age to begin sexual activity, indicate an age older than that at which they themselves first experienced intercourse.[9]
- In a recent survey in New York, twice as many boys (55 percent) as girls (27 percent) reported that having sex was a high priority.[10]
- 62 percent of male adolescents polled believe that "having sex" is acceptable with someone they have dated for a long time; 18 percent believe it is acceptable for people their age to have more than one sexual partner. 76 percent believe it is acceptable to "say no" to having sex.[11]
- While some family planning clinics do require parental consent for their services, 38.7 percent of boys in one study thought, incorrectly, that parental permission was always required for teenagers to visit a clinic. 51.6 percent thought, also incorrectly, that parental permission was required to purchase non–prescription birth control in a drugstore.[2]
- Many adolescent males do not feel comfortable attending family planning clinics which have traditionally focused on providing services for women. In 1982, the last year for which data are available, males comprised less than half of one percent of clinic users.[12]

Fatherhood and Its Impact on Adolescent Males

- In 1987 at least 105,364 teenage boys became fathers. 85,637 babies were born to parents who were both teenagers.[13] Since more than one-third of teenage mothers do not report the ages of their babies' fathers, these figures are assumed to be low.
- In 1985, 45 percent of the adolescent girls giving birth reported that the father of the child was 20 or older, 18 percent reported that the father was younger than 20 and the remaining 37 percent did not report any age for the father.[14] Rates of teenage fatherhood may be significantly higher in some urban communities.[13]
- A 1984 study revealed that 7 percent of all young men reported having fathered a child while a teenager. 10.9 percent of Latino, 14.8 percent of black, 11.9 percent of disadvantaged white and 4.6 percent of non–disadvantaged white males fathered children as adolescents.[16]
- A recent study determined that 84 percent of the fathers of children born to adolescent mothers live apart from their children. Only one-third of these fathers report visiting their children at least once a week one year after the child's birth.[17]
- Among adolescent mothers who live apart from the fathers of their children, 61 percent report that they receive too little financial support from their children's fathers.[17]
- Teenage fathers are much more likely to be high school dropouts than other male teenagers. Only 39 percent of teen fathers receive high school certification by age 20, compared with 86 percent of male teens who do not father a child.[16]
- Males who father children as teenagers are only half as likely to complete college as their peers who delay fatherhood.[16]
- Failure to attain success in an academic environment may lead some young males to drop out of school and seek personal fulfillment through other kinds of social roles, such as husband and father.[16] 18- and 19-year-old males with poor basic skills are three times as likely to be fathers as their counterparts with average basic skills.[9]
- In 1984 only 42 percent of all males ages 20 to 24 earned enough to support a family of three above the poverty line.[20]
- Studies indicate that teenage fatherhood, like teenage motherhood, is likely to be repeated from one generation to the next.[12]

Compiled by Elizabeth Armstrong, May 1990

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LESBIAN, GAY AND BISEXUAL YOUTH: AT RISK AND UNDERSERVED

Lesbian, gay and bisexual adolescents face tremendous challenges to growing up physically and mentally healthy in a culture that is almost uniformly anti-homosexual. Often, these youth face an increased risk of medical and psychosocial problems, caused not by their sexual orientation, but by society's extremely negative reaction to it. Gay, lesbian and bisexual youth face rejection, isolation, verbal harassment and physical violence at home, in school and in religious institutions. Responding to these pressures, many lesbian, gay and bisexual young people engage in an array of risky behaviors.

Research findings support the assertion that these young people are at higher risk for depression, suicide and HIV and other sexually transmitted disease infection. Anecdotal evidence suggests that gay, lesbian and bisexual youth are also at risk for alcohol and other substance abuse as well as pregnancies resulting from heterosexual experimentation. While interest in the experience of lesbian, gay and bisexual youth is growing, the body of research is small and virtually no research focuses on the specific experiences of young lesbians.

Research findings have led to the development of programs in many major cities that serve lesbian, gay and bisexual youth and to an increased awareness among some mainstream youth serving agencies about the unique needs of these young people.

Awareness of One's Own Homosexuality Occurs in Teenage Years

- A retrospective study of gay men indicates that the mean age of awareness of same-sex attraction occurred at age 14. The age for lesbians ranged between ages 16-19.[1]
- In a study of 29 gay and bisexual male teenagers ages 15-19, 31 percent recalled an attraction to men by age six and 69 percent became aware of that attraction between ages 11-16. For 27 of the 29 subjects, the mean age at the time of gay or bisexual self-identification was 14 years; two others believed that they "always knew" they were gay.[2]

Gay, Lesbian and Bisexual Youth Are At Risk of Suicide

- According to a 1989 study commissioned by the U.S. Department of Health and Human Services, suicide is the leading cause of death among gay male, lesbian, bisexual and transsexual youth.[3]
- Gay and lesbian youth are two to three times more likely to attempt suicide than their heterosexual peers and may comprise 30 percent of suicides among youth annually.[3]
- In a study of 137 gay and bisexual males ages 14-21, 29 percent reported a suicide attempt; half of those reported multiple attempts. Almost one-third made their first suicide attempt in the same year that they identified themselves as bisexual or homosexual.[4]
- Fifty-three percent of gay youths served by Los Angeles's Youth Services Department had attempted suicide at least once and 47 percent more than once.[5]
- The National Gay and Lesbian Task Force found that 41 percent of male adolescents seeking services at agencies for gay youths had attempted suicide, compared to 22 percent of the heterosexuals in the same age group at a shelter for runaways.[6]
- Two-thirds of randomly sampled U.S. psychiatrists believed that the suicidal acts of homosexual adolescents were more serious and more lethal than those of their heterosexual peers.[7]

Risky Behavior Puts Gay, Lesbian and Bisexual Teens At Risk for HIV Infection

- As of June, 1992, there were 872 reported cases of AIDS among teenagers (ages 13-19) in the U.S.[8], compared with 699 cases as of June, 1991[9] and 541 cases as of June, 1990.[10] Approximately 20 percent of all persons with AIDS are 20-29 years old; given the long latency period between infection and the onset of the disease, many were probably infected as teenagers.
- Young gay males face particularly high risks for sexually transmitted diseases (STDs). In a study of 29 gay or bisexual male adolescents ages 15-19, almost half reported having a previous STD.[11]

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- The mean annual number of sexual partners for gay males in a study of gay or bisexual male adolescents ages 15-19 was seven, with one-third of these being anonymous partners. One-half of respondents had heterosexual experiences during the previous year, averaging 5.6 different female partners each.[11]
- In a Boston survey of 1,841 gay and bisexual men, four out of 10 men under 23 years of age reported at least one instance of anal intercourse without using a condom during the past six months.[12]
- In a San Francisco study, almost half of participants ages 17-19 had participated in unprotected anal intercourse comparing to under a quarter of the 20-22 year-olds and under a third of 23-25 year-olds. Just over 14 percent of young men between 17 and 22 years old were HIV positive comparing to 10.4 percent of young men between 23 and 25 years old.[13]
- Many young gay males and lesbians engage in heterosexual sex attempting to hide or change their sexuality.[14] Thus, lesbian and bisexual youth are at risk of infection, which contradicts the prevailing, false assumption that lesbians are not at risk.

Societal Stigma Leads to Mental Health Problems

- Most gay, lesbian and bisexual adolescents hide their sexual orientation from their family and friends. This strategy of deception distorts almost all of the relationships the adolescent may attempt to develop or maintain and creates a sense of extreme isolation.[15]
- In a study of 29 gay or bisexual male adolescents ages 15-19, 72 percent of the youth had consulted mental health professionals and 31 percent had had a previous psychiatric hospitalization.[4]
- In a small study of gay or bisexual male adolescents ages 15-19, 58 percent regularly abused substances.[4]
- Fifty-four percent of 289 school counselors surveyed strongly agreed that students are very degrading toward fellow students whom they discover are homosexual and 67 percent strongly agreed that homosexual students are more likely than most students to feel isolated and rejected.[16]

Many Homosexual Adolescents End Up on the Street

- In a 1986 survey of street youth in Seattle, 40 percent of the youth identified themselves as gay, lesbian or bisexual.[17]
- One in four gay or bisexual males is forced out of the parental home prematurely due to issues surrounding sexual orientation. Up to half resort to prostitution in order to support themselves, thereby dramatically increasing their risk of HIV infection.[18]

Anti-Gay Physical and Verbal Assaults Are Common

- In a study conducted by the National Gay and Lesbian Task Force, 45 percent of the gay men and 20 percent of the lesbians surveyed were victims of verbal and physical assaults in secondary school because of their sexual orientation.[7]
- In a study of 500 New York City youths served by a gay/lesbian youth services agency, 40 percent reported that they had experienced a violent physical attack. 46 percent of those reporting physical assaults reported that the assault was gay-related. 61 percent of the gay-related violence occurred in the family.[19]
- Of 29 gay or bisexual male adolescents ages 15-19 surveyed, 55 percent reported verbal abuse from peers and 30 percent reported being physically assaulted. Half of the assaults occurred on school property.[3]

Helping Professionals Are Not Always Helpful

- Despite the mental and physical health risks faced by gay, lesbian and bisexual youth, many physicians do not discuss homosexuality with adolescent patients. Some feel that it is outside their realm; others fear that discussing it may upset teenage patients or their parents. Many feel too uninformed or uncomfortable to be helpful.[14]
- Of 289 secondary school counselors surveyed, one in six thought there were no gay students in their school. Twenty percent believed they were not very competent at counseling gay students.[16]

Lack of Adult Role Models Causes Further Isolation

- Gay, lesbian and bisexual adolescents are isolated from, and unsupported by, members of the adult homosexual and bisexual communities. Isolated from well-functioning gay, lesbian and bisexual adults, youth rarely have suitable role models who demonstrate by example the falseness of society's anti-gay stereotypes.[15,20]

The Facts

Substance Use and STDs

- Crack cocaine has been associated with an increase in the incidence of sexually transmitted diseases.[11] In San Francisco, there was a 35% increase in cases of gonorrhea among 15- to 19-year-olds between 1987 and 1988; the proportion of cases was greatest in neighborhoods with the greatest number of crack-related arrests.[9]
- In a study of sexually active adolescent males admitted to a substance abuse treatment program, 53% were found to have one or more sexually transmitted diseases.[12]
- The exchange of sex for drugs, particularly crack, plays a major role in the spread of sexually transmitted diseases.[11] A study of adolescent crack users found that one in four reported having been involved in an exchange of sex for drugs and/or money.[9]

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Adolescent Substance Use and Sexual Risk-taking Behavior

The use of alcohol, drugs and cigarettes by adolescents poses significant threats to their health. Yet the connection between substance use and other risk-taking behaviors is not often examined. Some research has found that there is a linkage between the use of cigarettes, alcohol and other drugs and sexual activity. Moreover, substance use may impair adolescents' ability to make judgments about sex and contraception, placing them at increased risk of experiencing pregnancy or becoming infected with a sexually transmitted disease, including HIV.

Increase in Adolescent Sexual Activity Paralleled Increase in Drug Experimentation

- Both experimentation with illicit drugs and sexual activity rose among adolescents over the last two decades. The increased rates of adolescent substance use and sexual activity may be linked either because similar factors influence both, or because engaging in one behavior increases the likelihood of engaging in the other.[1]
- Unlike the rate of sexual activity among adolescents, which continues to increase, illicit drug use among adolescents is declining. However, more than 4.5 million adolescents ages 12 to 17—or one out of five—have tried an illicit drug.[2]
- Adolescents who have lower expectations for academic achievement and who are more influenced by their peers than their parents are more likely than others to engage in risk-taking behaviors such as sexual activity, cigarette smoking and the use of alcohol and other drugs.[1,3,4]
- Adolescents who use marijuana are about three times more likely to be sexually active before age 16 than those with no drug history. The younger the age at first use of drugs, the greater the likelihood of early sexual activity.[1] Among white females under the age of 16, those who smoke cigarettes are four times as likely to engage in sexual activity as those who do not.[3,4]
- Females who initiate intercourse before age 17 are almost twice as likely as their peers who are not sexually experienced to begin using alcohol or marijuana within a year of first intercourse.[5]

Substance Use Impairs Judgment and Increases Risk-taking Behaviors

- Among adolescents, sexual activity is often unplanned and often occurs after drinking or drug use.[6,7] One study of adolescents with unintended pregnancies found that almost one-half had been drinking and/or using drugs before the act of intercourse that resulted in the pregnancy.[8]
- The use of alcohol and drugs has been shown to inhibit the ability to practice safer sex or to use contraception at all.[8,9] One study found that among sexually active adolescents who drink and/or use drugs, 16% used condoms less often after drinking and 25% after drug use.[7]
- A survey of college students found that 75% of the males and at least 55% of the females involved in acquaintance rapes had been drinking or using drugs just prior to the attack.[10]
- The use of crack cocaine is associated with high levels of sexual activity and risk-taking. A study of female crack users found that they reported twice as many sexual partners per month as non-users. One-third of black adolescent male crack users in another study reported ten or more sexual partners in the last year.[9]

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Rates of Sexual Activity and Substance Use Differ According to Race and Gender

- Several studies have shown that rates of alcohol, cigarette and marijuana use are higher among white adolescents than among black or Hispanic adolescents.[3,5,13] Black adolescents are more likely to be sexually active than their white or Hispanic peers.[1,3,5]
- Black adolescents report lower rates of alcohol and drug use than their white peers. Hispanic teens report more substance use than black teens, but only slightly less than white teens. Native American adolescents report the highest rates of alcohol and drug use; Asian-American teens report the lowest.[14]
- 89% of high school seniors report having tried alcohol.[15] White and Native American males report the highest rates of heavy drinking: almost half report having 5 or more drinks in a row in the last two weeks. One-third of the females of these groups report heavy drinking. Among black and Asian-American females, only one in ten reports heavy drinking.[14]
- 19% of high school seniors report daily use of cigarettes. Two-thirds of all adolescents have tried cigarettes; 29% report smoking within the last month. Females tend to smoke at slightly higher rates than males.[15]
- Four out of ten high school seniors report having tried marijuana. White males and Native American males and females report the highest rates of current marijuana use: one-fourth report using marijuana in the last month. Fewer than 10% of black, Puerto Rican, and Latin American females and Asian American males and females report marijuana use in the last month.[14]
- 9% of high school seniors report having ever tried cocaine, and about 4% report having tried crack.[15] Rates of cocaine use are lowest among black and Asian-American adolescents. Hispanic males and Native American males and females report the highest rates of cocaine use: between 7 and 9% of high school seniors in these groups report using cocaine in the last month. Among white high school seniors, 4% of females and 6% of males report using cocaine in the last month.[14]
- Males are more likely than females at any age to use marijuana or alcohol or to be sexually active. Among females at any age, white adolescents are more likely than black or Hispanic adolescents to have begun using alcohol or marijuana.[5]

Most Adolescents Perceive Risks, but Peer Pressure Plays a Role in Alcohol and Drug Use

- While only 23% of high school seniors believe it is harmful to try marijuana once or twice, 78% believe it is harmful to smoke marijuana regularly. 60% believe that trying cocaine once or twice is harmful. Nine out of ten believe regular use of cocaine is harmful.[15]
- Black adolescents are more likely than whites to perceive that drug use involves high risks, and to disapprove of drug use.[14]
- Adolescents perceive less harm in the use of alcohol than in the use of drugs. Only one-third of high school seniors believe it is harmful to take one or two drinks every day; almost half believe that it is not harmful to have five or more drinks once or twice a weekend.[15]
- 21% of high school students report feeling "a lot" of pressure to drink alcohol. 7% report feeling "a lot" of pressure to use drugs. Adolescents from socio-economically disadvantaged backgrounds are three times more likely than others to report feeling pressured to use drugs.[16]
- According to one survey, adolescents rate the mass media as their best source of information about alcohol and drugs. However, black adolescents report seeking information about alcohol and drugs from their families more often than do white adolescents. Moreover, white adolescents are twice as likely to believe what their friends tell them about alcohol and drugs as are black adolescents.[17]

Compiled by Elizabeth Armstrong, July 1991

Excerpt from the 24th Annual Gallup/Phi Delta Kappa Poll of the Public's Attitudes Toward the Public Schools

Distribution of Condoms by Schools

Ten years ago, free distribution of condoms in public high schools would have been unthinkable. Today, the fast-growing AIDS epidemic has moved a number of big-city school systems to adopt a policy of condom distribution. A trend is apparently in the making.*

Poll planners this year asked a series of questions to measure local support for the distribution of condoms in the schools. A majority of respondents (68%) would approve of condom distribution in their local public schools, although 25% of them would approve distribution only with parental consent. Majorities of the public believe that condom distribution in the schools would slow the spread of AIDS and other sexually transmitted diseases and, to a somewhat lesser extent, would reduce the number of pregnancies among students. The possibility that condom distribution would increase sexual promiscuity among students is seen as likely by a significant number of respondents; 40% say it would increase sexual promiscuity, 42% say it would make no difference, and 13% say it would actually decrease promiscuity.**

Several interesting, though perhaps predictable, demographic differences show up in the responses to these questions. For example, men are slightly less likely than women (39% to 45%) to approve of providing condoms without parental consent to all students who want them. Older and less-well-educated respondents and those who live in small communities or in the South are also less likely to approve of the practice. Catholics and Protestants are equally likely to approve of the idea (40% in favor).

*In the past year, school systems in several major cities have adopted programs to distribute condoms to high schoolers. New York, Los Angeles, San Francisco, and Seattle have policies in place, while Philadelphia, Chicago, and Baltimore have pilot programs. The legality of New York's program, which does not require parental consent, was upheld in a court case last summer. Interestingly, preliminary reports from cities with condom distribution plans show that only a small minority of students are taking advantage of them so far.

**A *Time*/CNN poll conducted by Yankelovich Clancy Shulman on 17-19 December 1991 showed that 58% of the public approved of having school health clinics provide students with contraceptives; 38% disapproved. (In the *Time*/CNN survey, the option "only with parental consent" was not included.) According to that poll, 41% of the public thought that distributing condoms in school would contribute to greater promiscuity; 54% thought that it would not.

"Wait! Is it too late for me to change my opinion?"

The first question:

Which one of the following plans regarding condoms would you prefer in the public schools in this community?

	National Totals %	No Children In School %	Public School Parents %	Nonpublic School Parents %
Provide condoms for all students who want them	43	44	41	38
Provide condoms only to students who have parental consent	25	24	27	24
Don't provide condoms to any student	25	23	27	29
Don't know	7	9	5	9

The second question:

In your opinion, which of the following would happen if condoms were provided in the local public schools?

	Increase %	Decrease %	No Effect %	Don't Know %
Increase or decrease sexual promiscuity among students	40	13	42*	5
Increase or decrease the number of pregnancies among students	14	64	17*	5
Increase or decrease the likelihood of contracting AIDS	12	71	12*	5
Increase or decrease the likelihood of contracting other sexually transmitted diseases	13	71	11*	5

*Volunteered answer.

	National Totals %	No Children In School %	Public School Parents %	Nonpublic School Parents %
Think would increase:				
Sexual promiscuity	40	37	43	48
Number of student pregnancies	14	13	14	17
Likelihood of contracting AIDS	12	11	13	15
Likelihood of contracting other sexually transmitted diseases	13	12	13	18

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CHAPTER TWO
DEVELOPING POLICY

Policymakers recognize the important role schools play in educating youth about HIV/AIDS prevention. The federal government supports state and local efforts with funds and technical assistance through the Centers for Disease Control and Prevention's Division of Adolescent and School Health, located within the Center for Chronic Disease Prevention and Health Promotion. Every state either mandates or recommends that schools provide HIV/AIDS prevention education. (See Attachment II.A.)

State legislation and policies adopted by boards or departments of education are more or less explicit about what must be taught. Over half of the states have developed their own curricula on HIV/AIDS. Some states require each school to appoint an AIDS Advisory Council; the state may even specify who sits on the council and define its responsibilities.

Strong institutional support for HIV/AIDS prevention and systems that promote community participation make it easier to design programs that meet local needs. It is in this context that school condom availability has recently gained momentum and support. Condom availability is no longer a novelty; schools with programs can be found in the suburbs and in rural communities as well as in major urban centers.

In September 1989, condoms were made available to students in the two high schools of Adams County, Colorado. Approved by the board of education in August 1988 as a component of a comprehensive HIV/AIDS policy, the program is probably the first district-wide condom availability program outside a school-based health center. The national media first focused on the issue in August 1990, when Public Schools Chancellor Joseph Fernandez announced his support for condom availability as part of a comprehensive education program to combat the epidemic rates of HIV infection among adolescents in New York City. Since then, Philadelphia, Los Angeles, San Francisco, Washington, D.C., Seattle, Boston and smaller communities such as Cambridge and Falmouth, Massachusetts and Santa Monica, California have adopted programs.

Even earlier, condoms and other contraceptives had been available through a number of school-based health centers (SBHCs) that provide primary care to enrolled students. Although the majority of centers do not provide condoms on site, the Center for Population Options (CPO) estimates that nearly 50 out of over 400 of these centers nationwide make condoms available as a health service. Some of these programs have been operating for years and have provided contraceptives (including condoms) mainly in an effort to address the problem of teen pregnancy. With the emergence of HIV/AIDS as the leading cause of death among young adults in some cities, condom availability programs are increasingly incorporated into more comprehensive prevention efforts. (Chapter 8 describes several SBHC condom availability programs.)

A list of cities in which schools and school districts have adopted or debated condom availability policies appears at the end of this chapter. The case studies found in Chapters 7 and 8 describe the steps which led to the adoption of the policy in several of these cities.

Policymaking can be a straightforward process, but often becomes more complex, particularly in larger school districts. This chapter primarily addresses school officials and administrators and advocates. It outlines the basic process of providing leadership and adopting a condom availability policy. At the end of this chapter are examples of policy documents from states and districts that permit condom availability.

I. PROVIDING LEADERSHIP

For a condom availability program to receive serious consideration, a credible individual or segment of the community must lead the public debate. In Massachusetts, a state board of education resolution was the impetus for local communities to discuss the issue; the resolution required every local school district to *consider* condom availability as a policy option. Similarly, state guidelines and state-level policies on HIV/AIDS and teen pregnancy prevention can be the framework for discussing a condom availability proposal. Local leaders, however, need to move the process forward and consolidate local support.

Schools are complex institutions that respond to federal, state and local mandates as well as to the needs of parents and students. Those leading the condom availability effort must be very familiar with school operations and how policy is made and implemented.

Ideally, the school superintendent and his or her staff provide leadership in establishing a condom availability proposal. Whether or not he or she exerts leadership on behalf of a program, the superintendent plays a major role in developing school policy. School boards rely heavily on these administrators for recommendations on programs and policies the superintendent will implement.

If the superintendent is unwilling or unable to support the policy, however, a group of principals, public health officials, official AIDS advisory groups or community groups can initiate the policy discussion. (See Chapter 3.) Community organizations and health professionals unfamiliar with school policy and procedures will find a useful guide in *How Schools Work and How to Work with Schools: A Guide for Health Professionals* published by the National Association of State Boards of Education. (See Attachment II.C for information on how to order the publication.)

In fact, initial leadership in policy and program development has emerged from a variety of sources, including:

- city government (elected officials, health department)
- school board members
- school superintendents and principals
- state, local or district HIV/AIDS task forces
- community based organizations or activists
- school-based health center staff
- students.

In New York City, for example, the early local leadership was taken by community advocates – including parents, faculty, AIDS activists and health practitioners – but eventually the school superintendent, the Chancellor, adopted that leadership role as his own. In Washington, D.C., however, the leadership in policy and program development was derived from the Mayor and Health Commissioner, who received strong and well-organized support from the community. The school superintendent eventually supported the concept, but never declared ownership of the program.

A. *Establishing the Context for a Proposal*

School condom availability programs generally operate in one of two contexts: as a component of HIV/AIDS prevention or sexuality education, or as a health service delivered by health professionals or a school-based health center.

There are good reasons for adopting either approach, depending on local concerns. Programs necessarily combine elements of both education and health care and employ professionals from both fields. Condom availability programs have both educational and public health goals. Condoms themselves are a health aid; however, they are non-invasive and widely available without a prescription and in non-medical settings. Additionally, teaching effective condom use and negotiating skills are educational goals.

Deciding whether to make condoms available as a health or as an education function is a policy choice that has important implications for the program's design and implementation. Decisions about staffing, materials or services, parental consent or opt-out requirements and funding are often related to that choice. The decision may hinge on the different ways the law treats health and education services, the potential sources of funds for the program or the primary source of leadership and support.

"The main problem with condoms is that many people do not know how to use them."

C. Everett Koop, U.S. Surgeon General, 1987.[6]

B. Developing an Action Plan

Regardless of whether leadership is from school officials, parents or community advocates, the following tasks should be considered in developing an action plan:

- making a case for condom availability (Chapters 1,3 and 5)
- choosing a goal and developing a policy proposal (Chapters 4 and 5)
- building support among community stakeholders – the school, the medical community, city government, parents, students, religious leaders, civic organizations, advocacy groups, etc. (Chapter 3)
- building support among the community's political leaders (Chapter 3)
- inspiring policymakers to action (Chapters 2 and 3)
- dealing with conflict and opposition (Chapter 3)
- using media attention to educate the public and policymakers (Chapter 3).

In preparing the proposal, the critical constituencies are members of the public health community and the school community, including parents, students, principals and other administrators, local school committees, health educators, school nurses, budget officers and teachers. In setting policy, the school board will weigh the views of those responsible for administering the program, as well as of parents and community leaders. Involve or consult representatives of these groups in planning, to ensure that basic concerns are anticipated. Gather teams or working groups of key school staff to brainstorm strategies and carry out the plan. (See suggestions in the chapters listed in the parentheses above.)

C. Obtaining Assistance

From Community Groups. When proponents within the school system, government agencies and outside organizations share information and collaborate on strategies, they form a powerful and effective alliance. School officials seeking help from community groups should start by calling a meeting of supportive local groups and asking their help in educating policymakers and the community. Let them know exactly what they can do and provide them with information to begin. Ask what other groups need to be involved in the strategy. (See "Building a Coalition for Advocacy" in Chapter 3.)

From Advisory Councils or Local Professionals. Many school districts have AIDS advisory councils comprised of individuals with clinical experience working with adolescents and of researchers, academics, health care providers, psychologists, policy analysts, religious leaders, etc. In several cities, it was an advisory council that initiated the condom availability policy debate. If an AIDS advisory council does not exist, one could be established. Although this is a ready-made panel of experts, others can be enlisted to advise school officials on policy impacts and implications as well. They can also help evaluate challenges to condom availability and develop effective responses. Individuals in the local community should be solicited to testify before the board or speak to the media in their area of expertise.

From National Experts. A clear command of the facts is vital in responding to misinformation and misrepresentation of data. Consult nationally recognized experts either directly or through their publications. Chapter 9 contains articles and lists organizations that provide information, expertise or the ability to put schools in touch with leading experts in the field.

From Other Schools. CPO's National Clearinghouse on School Condom Availability tracks programs throughout the country and can provide information and connect school officials or advocates with leaders elsewhere. State departments of education or health might be able to provide information about other school districts' condom availability efforts and about strategies for developing community consensus and support.

D. Preparing for Community Debate

In some communities, school officials have been careful to treat condom availability in a low-key style. By dealing with the issue matter-of-factly and without publicity, they believe they can avoid debilitating controversy.

Such a low-key approach to policy development might be effective in communities where there is unlikely to be significant opposition among school board members or city officials. It may also work well if *existing* school services such as health centers or school nurses' offices were to make condoms available.

It is impossible, however, to avoid publicity altogether and opposition is likely to surface after the decision is made. School officials who supported the policy might be charged with "sneaking it through," "cutting parents out of the process," "overreaching their authority." Officials should anticipate efforts to reverse or revise the policy, either through political pressure or through legal challenges.

If a school district has debated sexuality or HIV/AIDS education curricula, school officials may have a good sense of potential sources and strength of opposition to condom availability. If opposition is neither well-organized nor driven by national groups and if policymakers are prepared to weather the conflict, officials can address specific concerns and it is likely vocal opposition will fade, dire predictions be proven unfounded and the policy be accepted.

On the other hand, many communities – especially those with a well-organized conservative religious presence – must be prepared for highly charged conflict. Community organizing is an extremely important strategy in limiting the impact of vocal opposition from a small minority.

Some officials feel that conflict has a positive side in that it can help to focus the public's attention on issues it would otherwise ignore: teenagers, sex and AIDS. New York City school officials' strong stand on including condom

availability in a comprehensive HIV/AIDS education program brought national attention and enormous conflict to their door. These officials understand that among their accomplishments are the heightened awareness of the problem of HIV/AIDS throughout the city and a new ability on the part of both students and adults to talk openly about their concerns and take actions to address them. They also point to the nationwide debate and long list of school districts that have subsequently adopted or considered programs of their own, as a sign of the far-reaching impact of their deliberations.

Knowledge of their community allows school officials to choose the most appropriate approach to take in seeking to implement a condom availability program. Regardless of whether the decision is made to seek a low or higher profile for the policy decision, outreach to community groups is essential to building a base of support. (See "Building Community Support" and "Responding to the Opposition" in Chapter 3.)

E. Gauging Community Support Through Public Opinion Surveys

One method of gauging community support is the use of public opinion polls. The public usually assumes parents oppose making condoms available in school. National polls suggest, however, that this is not the case. Survey results can effectively challenge this assumption in the local community. (See "Surveys" in Chapter 5.)

Surveys have been used effectively in Baltimore, Maryland and Portland, Oregon to support policies making condoms available in existing school-based health centers. In Baltimore, the survey was limited to parents of students enrolled in the school health centers. The Portland survey included non-parent residents, parents and students. (See the case studies in Chapter 8 for more information on the surveys.)

F. Planning for Media Coverage

Once a condom availability policy is publicly proposed, the issue will be debated throughout the community. The media will seek out signs of conflict. Since school condom availability is a new concept, schools may receive calls from national as well as local media.

It is not always possible to control when the media will announce the proposal. The most important consideration, however, is that it not come as a surprise to school board members and key city officials. They should be briefed on the proposal and given an opportunity to support it. If outreach by school officials and outside groups has been effective, these key stakeholders will be informed about the need for action and their input will have been solicited. Even if some of them oppose the initiative, early briefing will reduce the potential for emotional reactions. (See "Designing a Public Education Campaign" in Chapter 3.)

By taking the following steps, school officials can maximize the opportunity provided by the press and achieve greater control over media coverage.

Take Advantage of Public Awareness Created by National News. Reports of dramatic research findings, a story of a teen living with AIDS or a celebrity's personal story can provide openings for the announcement of a condom availability program.

- Soon after Earvin "Magic" Johnson announced his HIV-positive status, officials in Portland, Oregon, began planning the announcement of a new city policy allowing condoms in school-based health centers.

- Within weeks of the release of a major study estimating that as many as one in 45 adolescents in the District of Columbia is infected with HIV and that one in 67 babies is born to an HIV positive mother, the mayor announced the details of an HIV prevention initiative that includes condom availability in the schools.

Create Public Awareness Through a Series of Local Events and Coordinated Public Education Strategies. Coverage of community HIV/AIDS-related activities may prepare the community to support condom availability. Call attention to: local activities in recognition of World AIDS Day, a press conference releasing results of a local needs assessment or survey, the city council's resolution declaring AIDS Awareness Week, etc. Schools can work with the health department, city officials or community organizations in planning these events.

Maintain Positive Media Relationships. Clear procedures for initiating and responding to media contacts will make handling press calls easier. Route calls from the press to one designated contact. This practice establishes a regular contact for reporters and ensures consistency in the message. It also improves reliability in follow-up on any materials the interviewer requests and provides a screening mechanism for interviews. The press contact should try to respond to all media calls. Even if an interview with the spokesperson is not granted, the contact can provide useful background materials and information to the reporter.

Prepare a Press Packet. Compile and distribute a press kit that includes information about the school population, the community, the rates of pregnancy and sexually transmitted diseases – including HIV – in the community, the school's current program for addressing these problems and a description of the proposal. The kit can contain letters of support, copies of relevant articles, results of any surveys or needs assessments, advisory panel reports, etc. This written information efficiently provides much of the background reporters need, saves staff time and decreases the risk of inaccurate reporting.

Prepare the Spokesperson for Interviews. Even the most experienced spokespeople benefit from anticipating difficult questions and practicing the answers in role-play situations. Knowing ahead of time who is calling and the focus of the interview helps the spokesperson to organize his or her thoughts and to decide which are the most important points to communicate. By being clear and succinct and demonstrating thoughtfulness, sensitivity and candor, the spokesperson can diffuse criticism and convey confidence in the proposal.

Consider Holding a Press Conference. If the school superintendent makes the proposal for condom availability, it is likely to be presented for the first time at a school board meeting attended by reporters. Media may also attend any public meeting at which the superintendent is called upon to respond to questions from the community. At some point it may be appropriate for the superintendent to respond directly to questions from the media at a press conference.

A plan spearheaded by the health department will usually be announced at a press conference. In addition to the health commissioner and other representatives of local government and the school board, the presence of community representatives signals broad-based support for the plan. Invite students, parents, clergy, representatives from school-based health centers, local youth-serving agencies and advocacy groups to attend and make written statements available to the press.

Consider Seeking Editorial Support. Undoubtedly, local newspapers will take a stand on any condom availability proposal. If their support is critical for approval, it may be useful to arrange a meeting with the editor or editorial board to make the case personally. The school district's public relations officer and one or two spokespeople should attend the meeting. If possible, a public health official should be available to respond to medical or epidemiological questions about HIV/AIDS. This group should provide background materials and be prepared to respond directly to arguments against the program.

One of the most dramatic moments in the press conference to announce her five-year plan to address the AIDS epidemic came when Washington, D.C.'s Mayor Kelly accepted a petition signed by 1,600 high school students favoring condom availability.

II. MAKING POLICY DECISIONS

While some states' laws prohibit the availability of contraceptives on school property, the school board is generally responsible for establishing school policy on condom availability. If the law permits, the school board may authorize or recognize the authority of another individual or agency – such as the superintendent or the health department – to make condom availability decisions on the basis of existing policies or laws regarding HIV/AIDS education and health services.

For example, in Washington, D.C., school condom availability was one component in a city-wide, five-year plan for AIDS prevention spearheaded by the Health Commissioner and the Mayor. The school board never voted on the policy, although its members expressed overwhelming support for the initiative. Had school board members actively opposed the measure, the health department might have faced a serious legal or political challenge.

A. School Board Procedures

When dealing with a controversial issue it is especially important that the school board follow proper procedures for adopting policy. This process should be open, fair and allow for input from the community. The board is likely to follow the steps outlined below.

Recognize the Need for Policy; Define the Problem

The issue of condom availability may be brought before the board by advocacy groups, the medical community, the school superintendent or board members. The school board must clarify its views of the problem's scope and its goal. For instance, if the goal is simply to make condoms easily accessible, then condom availability is the simple response. If the goal is to prevent HIV infection, then, in addition to condom availability, the board must include strategies to improve teens' capacity to use condoms, such as counseling, outreach and follow-up. If the goal is to prevent high-risk behavior, then the school must also consider multi-component interventions, parental involvement and outreach, higher level skills-building for communication and access to health, family planning and mental health services.

Gather Information

Needs Assessments. Decisions should not be based merely on emotions or in response to political pressure. The school board needs the facts about adolescent risk-taking behavior and how the school and community may already be addressing it. Unless a needs assessment has already been prepared, the board should request one from the superintendent or a task force.

For More Information See

- Chapter 5 for suggestions on needs assessments and focus group research.
- Chapters 3 and 8 for using public opinion polls.
- Chapter 6 for a discussion of the legal issues raised by school condom availability.
- Chapter 4 for a discussion of various models for condom availability programs.

Legal Opinions. The school counsel should be consulted or asked to write an opinion on federal, state and local legal issues raised by a condom availability program. The board should also ask for an analysis of how condom availability is in keeping with, or in conflict with, existing school policies. If there are conflicts, the board must be prepared to address them.

Expert Opinion. The board should be briefed directly by local public health authorities on the prevalence of STDs and teen pregnancy. They may also call on experts in the fields of adolescent health, HIV/AIDS and pregnancy prevention to better understand implications for the school population.

Community Opinion. A task force, advisory council, or superintendent may be asked to gather input from the community through public hearings, meetings with parent groups, solicitation of written comments, or public opinion surveys. Using forums in addition to official school board meetings to solicit the public's views allows for concerns to be identified and addressed and may more accurately reflect public opinion.

Gathering all of this information takes time and financial resources. However, most boards will find that providing sufficient funds to do a good job of data gathering pays off in the end.

Seek Recommendations from the Superintendent, Policy Committees, Task Forces, Citizen Groups, Specialists, etc. If the superintendent takes a leadership role, it is appropriate for the board to rely on him or her to present a specific recommendation or plan.

If a special task force is appointed by the board or the superintendent to draft a plan or a policy recommendation, members should have experience with the issues and in working with adolescents, or be directly affected by the proposed program. Members may include:

- principals and/or board representatives
- HIV/AIDS and health educators
- school nurses, counselors, psychologists and/or social workers
- experts in adolescent health
- representatives of teen pregnancy prevention organizations
- parents
- students
- representatives of youth-serving and/or community organizations.

Encourage broad representation from the community. The board should consider appointing business and religious leaders who interact regularly with young people.

Discuss, Debate and Decide on Content of Program; Consider Alternatives and Consequences. The board may discuss the proposal several times, raising questions that require further research, or it may suggest changes needed before members are ready to consider a written policy. Additional legal questions may also emerge from specific recommendations. This process generally builds a working consensus about what the board hopes the policy will accomplish, the scope and limits of the policy, and the context of the program.

Board members will address concerns such as:

- Should the policy include a simple affirmation that condoms will be available in the school and leave the program's design to the superintendent or local school?

- How specific should the policy be about staffing, location, counseling, parental consent, etc.?

Hold a First Reading. Usual rules about public hearings should be followed and the community should be notified in advance about board hearings or public meetings when condom availability is on the agenda. The potential for emotional conflict makes it important that ground rules for public comment be set in advance and adhered to by the moderator. These might include: limiting the number of speakers; restricting the length of time each person can speak; limiting speakers to residents of the school district; alternating speakers between proponents and opponents of the proposed policy; making arrangements to accept written comment; and ruling defamatory statements and personal attacks out of order. To keep speakers from exceeding their time limit, establish a warning system that signals the need to summarize or conclude, and control the microphone from the chair.

The board may choose to schedule a meeting devoted entirely to public testimony on the condom availability proposal. A period should be set to receive written comments from the public. If the board does not have a standard procedure for sharing written comments, it should clarify how to handle these comments.

Hold Second Reading; Adopt the Proposal. As a result of the hearings or in response to written comments, incorporate any changes or clarifications into the draft policy. If these are major, a second round of hearings on the revised proposal may be necessary. If not, the board should be ready to vote on the proposal. Formal amendments are often offered and voted on at this time.

Decide Whether to Review the Implementation Plan. Once the policy is official, the superintendent has the responsibility for setting the implementation guidelines. Some school boards routinely review administrative guidelines that flow from a policy, but boards will have different procedures. In *Becoming a Better Board Member: A Guide to Effective School Board Service*, the National School Boards Association cites three reasons for such a review:

- To determine whether the superintendent understands the intent of the policy.
- To help catch any problems with the procedures that are developed.
- To learn from the administration if certain aspects of the policy are going to be more difficult or expensive to implement than the board anticipated.

By reviewing the guidelines, the board has the opportunity to reiterate its support for the policy; however, this step is most likely to be required when the school board vote is close or unresolved issues remain. Unless it is standard procedure, review or approval of the guidelines may be considered unnecessary when the superintendent has been involved in developing the policy and the local school has been involved in planning the guidelines. If the board wishes to monitor the program's implementation, it should request periodic progress reports.

Included at the end of this chapter are condom availability policies from:

- New York City
- Los Angeles
- Massachusetts
- Philadelphia
- San Francisco
- Adams County, Colorado.

The 1992 Report & Recommendations of the Hawaii Governor's Committee on AIDS is also included.

B. Anticipating Community Reaction

After a policy is adopted, schools may experience continuing controversy. Board members may find themselves challenged in their bid for reelection; lawsuits may be filed challenging the policy. If the case is made clearly to the public, the community is educated adequately on the issue and the process is fair and open, these challenges are unlikely to succeed.

In one school district, opponents of the plan put up a complete slate of their own in the local election. Board members' concerns that their support for condom availability would result in their defeat, however, were disproved when all major proponents of the policy were reelected with comfortable margins. Similarly, none of the lawsuits filed against condom availability programs has succeeded in blocking implementation to date. (See Chapter 6.)

The school board and administrative staff's effectiveness in collaborating with health professionals and community groups while condom availability is being considered will help maintain community support once the program is in place. Subsequent chapters elaborate how to build and maintain public support while developing a model that will meet the community goals for a condom availability program. Schools cannot achieve these goals in isolation and will need to collaborate with health and community groups throughout the process of planning, implementing and evaluating a program.

CHAPTER TWO ATTACHMENTS

A. School HIV/AIDS Education: State Requirements/Recommendations

B. Cities or Schools with School Condom Availability Programs

C. *How Schools Work and How to Work With Schools: A Guide for Health Professionals*, introduction and purchasing information.

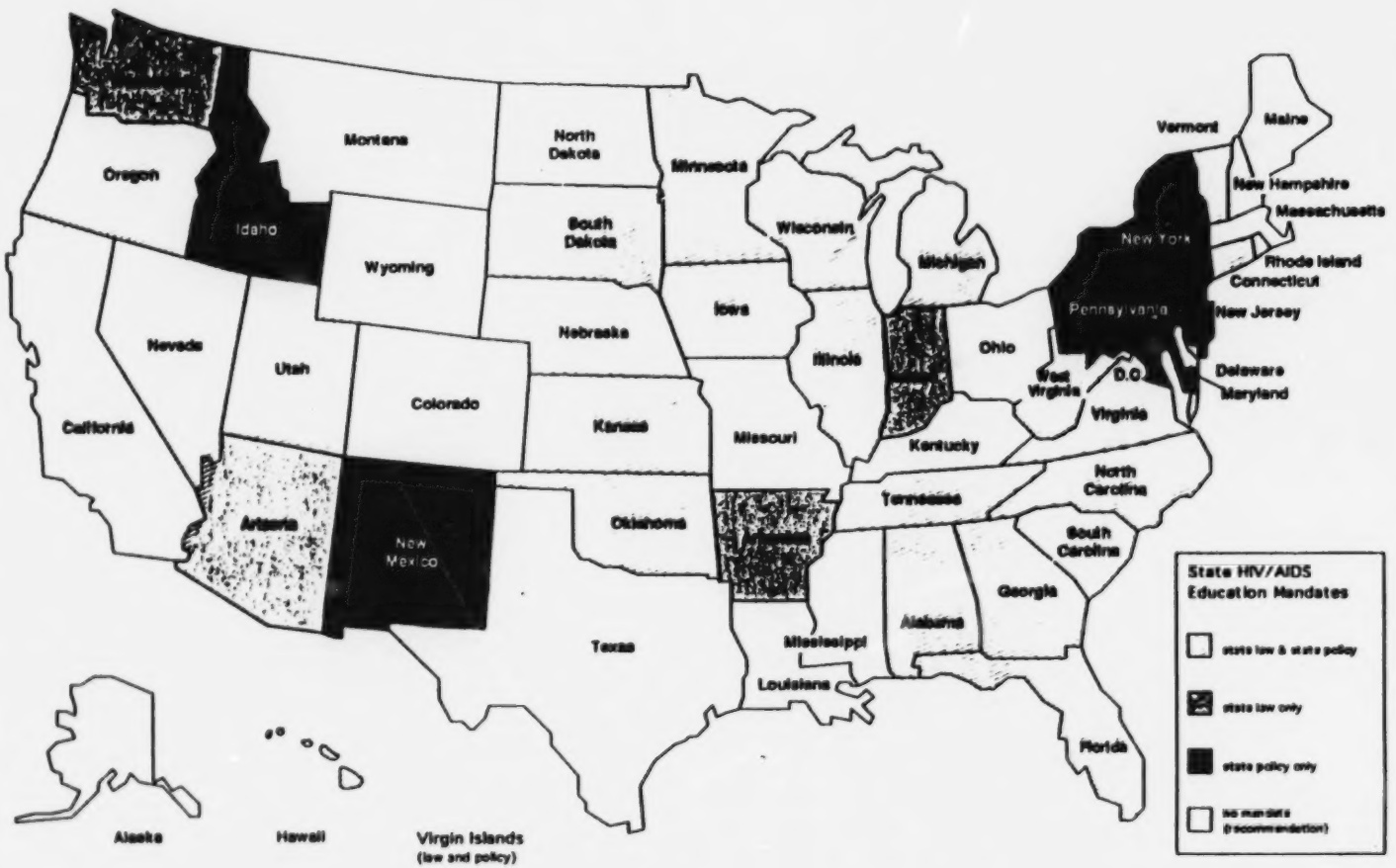
D. Condom Availability Policies:

1. New York City Board of Education
2. Los Angeles Unified School District Board of Education (Excerpt from minutes)
3. Massachusetts State Board of Education
4. Philadelphia Board of Education
5. Adams County, Colorado, School District #14
6. Recommendations for Policy: Governor's Committee on AIDS, Hawaii
7. San Francisco Unified School District

E. Editorial Support for Condom Policy:

1. *The Baltimore Sun*, Baltimore, October 25, 1990
2. *The Baltimore Sun*, Baltimore, November 21, 1990
3. *The Boston Globe*, Boston, February 20, 1990
4. *The Boston Globe*, Boston, June 13, 1992
5. *The Philadelphia Inquirer*, Philadelphia, June 26, 1991
6. *The Washington Post*, Washington, May 13, 1992
7. *The Washington Post*, Washington, April 14, 1992

School HIV/AIDS Education: State Requirements/Recommendations



Sex Information and Education Council of the U.S. (SIECUS). *Future Directions: HIV/AIDS Education in the Nation's Schools,* New York: SIECUS, 1992. Reprinted with permission.

CITIES OR SCHOOLS WITH SCHOOL CONDOM AVAILABILITY PROGRAMS

Identified, as of 2/18/93

School-Based Health Centers Programs Implemented

Nationally, CPO estimates that over 50 school-based clinics health make condoms available to sexually active students, including:

Little Rock (AR)
Chicago (IL)
Baltimore (MD)
Portland (OR)
Minneapolis (MN)
Philadelphia (PA)
Cambridge (MA)
Los Angeles (CA)
Quincy (FL)
Miami (FL)
Dallas (TX)
New York City (NY)
Portsmouth (NH)
Culver City (CA)

School-wide or district-wide programs implemented

Falmouth (MA)
New York City (NY)
Philadelphia (PA)
Martha's Vineyard (MA)
Commerce City (CO)
Hatfield (MA)
Los Angeles (CA)
Washington (DC)
Santa Monica (CA)

Programs approved and being designed

Seattle (WA)
Newton (MA)
Brookline (MA)
Provincetown (MA)
Holden (MA)
Chelsea (MA)
Somerville (MA)
Sharon (MA)
Lincoln/Sudbury (MA)
San Francisco (CA)
Northboro (MA)
Northhampton (MA)
Amherst (MA)

Programs rejected

Chester (VT)
San Lorenzo Valley (CA)
Springfield (MA)
Randolph (MA)
Weymouth (MA)
Grafton (MA)
Laurence (MA)
Norwood (MA)
Everett (MA)
North Andover (MA)
Southbridge (MA)
Talbot County (MD)
Tamalpais HS, Marin Co. (CA)
Worcester (MA)
Dedham (MA)
Canton (MA)
Hopedale (MA)
Fitchburg (MA)
Swampscott (MA)
Grafton (MA)
Reading (MA)
Southwick-Tolland (MA)
Swansea (MA)
W. Springfield (MA)
Kennebunkport (ME)
North Shore (WA)
Palmer (MA)
Whitman (MA)
Lake Washington (WA)
Uxbridge (MA)
Winchester (MA)
New Bedford (MA)
West Newbury (MA)

The Center for Population Options
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HOW SCHOOLS WORK AND HOW TO WORK WITH SCHOOLS

A GUIDE FOR HEALTH PROFESSIONALS

Janice Earle
William Kane
Candace Sullivan

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National Association of State Boards of Education

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INTRODUCTION

A growing number of physicians and health professionals are seeking to influence or improve health education and we commend your desire to be a part of this movement. Your success or failure in this endeavor will depend largely upon your ability to learn HOW SCHOOLS WORK AND HOW TO WORK WITH SCHOOLS.

All too often, outsiders who try to work with schools find themselves puzzled and frustrated.

- Why is it so difficult to address controversial issues in schools?
- Why are offers of assistance sometimes met with resistance?
- How can an individual influence school policy?
- If one wants to work with schools, how in the world do you gain access?

These are some questions that this pamphlet will help answer.

Educators are currently being asked to address a wide variety of health issues with which they have minimal expertise. These include teen pregnancy prevention, alcohol and drug abuse, environmental conditions including radon and asbestos, prevention of sexually transmitted diseases, anti-social behavior, and suicide. The spread of HIV infection is the newest and most critical health issue confronting them.

The Centers for Disease Control is recommending that prevention of HIV infection and other health risks be part of a comprehensive school health program that addresses the broad range of health risks to young people. We share that belief. What you need to understand, however, is that a comprehensive school health program is a new idea to many educators and many are unsure how to proceed.

As a community leader, you have a right and a responsibility to be interested in the present and future health of the children in your community. Influencing young people depends on one's ability to gain access to them. Because most young people under the age of 16 are in schools, health professionals must work with schools to reach significant numbers of young people.

This pamphlet is aimed at those of you who want your local medical society or other group of concerned health professionals to work with schools on an on-going basis. It is written to help health professionals understand how the education system works — *how* the governance structure operates, who's in charge of what, and where there are leverage points for action — so that the experience of working with schools is one that yields systemic improvements in school health programs. Otherwise, schools and the community will not be able to benefit fully from the guidance and expertise of the medical profession.

Copies of How Schools Work and How to Work with Schools are available for $6.50 each (prepaid) from the National Association of State Boards of Education, 1012 Cameron Street, Alexandria, VA 22314; (703) 684-4000.

Policy, New York City Board of Education, Approved February 1991

CPO 1993--ATTACHMENT II.D.1

AUTHORIZATION FOR THE CHANCELLOR TO IMPLEMENT A CONDOM AVAILABILITY COMPONENT AS PART OF AN OVERALL HIV/AIDS EDUCATION PROGRAM IN THE HIGH SCHOOLS IN THE CITY SCHOOL DISTRICT OF THE CITY OF NEW YORK

The Chancellor presents the following resolutions for adoption:

WHEREAS, New York State Commissioner's Regulations, Subchapter G, Part 135 state that all schools should provide appropriate instruction concerning the Acquired Immune Deficiency Syndrome (AIDS) as part of required courses grades K-12; and

WHEREAS, The Chancellor will establish an HIV/AIDS Advisory Council, with representation from students, administrators, teachers, parents, clergy, school board members and representatives from health agencies, reflecting the racial and ethnic diversity of the school system as well as the expertise of reputable health and social service professionals, to advise on the implementation of HIV/AIDS education programs; and

WHEREAS, The New York City HIV/AIDS Curriculum K-12 presently being revised with the involvement of parents, general, special education and bilingual educators , will be ready for implementation in the fall of 1991, and the 7-12 curriculum will include information about HIV transmission through IV drug use, the dangers of early sexual activity, emphasizing abstinence, responsible decision-making and behavior and the proper use of barrier methods against HIV infection, the revised curriculum levels will be translated into other languages and adapted to be appropriate for children with special needs; and

WHEREAS, As part of the plan for HIV/AIDS education, every high school in New York City will have an HIV/AIDS Education Team with mandated representation from parents, students and school staff to develop school-based plans for HIV/AIDS education, including providing information about protection from HIV infection and identifying counseling resources; and

WHEREAS, The Office of the Chief Executive for Instruction in collaboration with the New York City Department of Health and other agencies will provide training, support and technical assistance in the development and implementation of the plans to the HIV/AIDS Education Teams; and

WHEREAS, The Chancellor or his designee will review and approve each high school's HIV/AIDS Education Plan prior to the implementation of the plan; such plan must include the identification of at least one space in the school where health resource materials will be available, and provide students with access to a trained adult on the school site, capable of counseling students on health issues including teen sexuality; and

WHEREAS, The Office of the Chief Executive for Instruction as well as staff deployed by the Office of the Chief Executive for Monitoring and School Improvement will monitor to ensure the implementation of the curriculum and the formation of local advisory councils on HIV/AIDS education; and

WHEREAS, Adolescents are at an increasingly high risk of contracting HIV and becoming ill with AIDS therefore making HIV infection one of the greatest threats to the health and welfare of the children of New York City; and

WHEREAS, The Commissioner of Health of the City of New York indicates that New York City has a greater number of teenagers with AIDS than any other city in the nation; and

WHEREAS, Condoms have been cited by the former Surgeon General of the United States to be the best protection against the sexual transmission of the HIV virus; now be it therefore

RESOLVED, That the Board Of Education hereby authorizes the Chancellor to make condoms available in High Schools as part of the school's overall HIV/AIDS Education Program; and be it further

RESOLVED, That prior resolutions of the Board of Education that are inconsistent with this resolution are hereby modified to conform to this resolution.

EXPLANATION

New York City is in the midst a health crisis which is affecting students in our schools. While only 3% of the nation's 13-21 year olds reside in New York City, according to the city Commissioner of Health, our city has 20% of all reported AIDS cases in this age group, in the United States.

In New York City AIDS is now the leading cause of death for women between the ages of 25 and 34. With an average latency period of ten years between HIV infection and the onset of symptoms these women, along with thousands of other young adults, contracted the disease as teenagers. It is no longer possible to ignore the spread of this infection among our youth.

The portrait of the AIDS epidemic among adolescents in New York City differs from that of adults. Statistics demonstrate that a greater proportion of youth as compared with adults with AIDS are female, black and Hispanic and were infected through heterosexual contact. In addition, sexually active teens have the highest rates of sexually transmitted diseases. This is largely due to ignorance about sexually transmitted disease and lack of skill in using preventive measures. The behaviors that put adolescent children at risk for venereal diseases also place them at risk of HIV infection.

The Chancellor will implement all aspects of the expanded HIV/AIDS education program described in this document, and through the adoption of this resolution, be authorized to permit high schools to make condoms available as part of a school's overall HIV/AIDS education and prevention program.

Respectfully submitted,

Joseph A. Fernandez
Chancellor

Excerpt From Minutes, LA Unified School District Board of Education, 1/21/92

M. MISCELLANEOUS BUSINESS

1. Motions and Resolutions for Adoption — ADOPTED AS AMENDED SEE MINUTES*

a. Mr. Horton's motion noticed on December 16, 1991:

The Board of Education voted to approve the recommendations in the HIV/AIDS Education Blue Ribbon Task Force Report, as amended, listed below in concept as a policy, and as explained by the accompanying staff recommendation:

~~Be it resolved that the Board of Education of the City of Los Angeles adopt the twelve recommendations outlined in Section III of the HIV/AIDS Education Blue Ribbon Task Force Report by mandating the Los Angeles Unified School District to:~~

1. Train all certificated, classified, and volunteer staff on all aspects of HIV virus/AIDS infection including prevention, testing and treatment;

Staff Recommendation
Staff supports the policy of appropriate training, and the implementation to the extent possible within existing resources. Staff recommends that the implementation specifics (pages 22-25) be reviewed in detail by staff for cost implications and negotiations requirements.

VOTE: 6 ayes, 1 no, Mrs. Boudreaux

2. Provide appropriate resources for staff support and information;

Staff Recommendation
Staff supports a policy statement that appropriate resources should be developed and made available. However, because of cost implications, at this time staff recommends that the Board approve the policy in concept only and direct staff to do the following:

a. Identify what could be done within existing resources.

b. Pursue grants, foundation money, etc.

c. Work with health agencies, Center for Disease Control, etc.

d. With respect to the implementation specifics (pages 25-26), that staff review them for cost implications and negotiations requirements.

e. That, in any materials or presentations staff makes, it be made clear that the District is committed to an appropriate informational policy, but is restricted by the unavailability of resources.

VOTE: 6 ayes, 1 no, Mrs. Boudreaux

3. Develop and annually update HIV/AIDS education curricula ~~in accordance with the guiding principles in Section I. of the Report~~ for elementary schools, adult education centers and children's centers, and annually update the current curricula for sixth grade and junior and high school students;

Staff Recommendation
Supports the policy of an ongoing review of curriculum; provided, however, that the implementation principles (pages 14-19) and specifics (pages 27-29), in keeping with established practice, be reviewed by staff and presented to the Educational Reform, Restructuring, and Curriculum Committee prior to any implementation.

VOTE: 6 ayes, 1 no, Mrs. Boudreaux

4. ~~Expand the use and increase the number of school-based clinics and that mental health services and linkages be included to anonymous HIV testing and treatment for those testing positive;~~ Commit to continued support of the existing three clinics; direct staff to look into additional resources for possible additional clinics; and direct staff to aggressively follow up on efforts toward coordinated services with other agencies, community-based organizations and community groups to provide health services for our youth;

Staff Recommendation
Staff recommends that the Board approve the concept of expanding School-Based Health Clinics within existing Board policy and resources. Regarding implementation specifics (pages 29-30), staff recommends that the Board direct a review by staff of these specifics in light of current policy and cost implications.

VOTE: 7 ayes

5. Make condoms available at ~~every secondary school site in the District~~ senior high schools, subject to the parental approval guidelines currently used for health education classes;

Staff Recommendation
Staff recommends that the Board adopt the policy for condom availability only at senior high schools, and only with parental consent. If the policy is adopted, then the procedure regarding condom availability would be to continue to review the issue with the Los Angeles County Department of Health Services, seeking to determine appropriate County, District, and other community-based resources which might be available for this purpose.

VOTE: 4 ayes, 3 noes, Mrs. Boudreaux, Ms. Quezada, Mr. Furutani

6. Allocate additional time in the school year for AIDS prevention education and related subjects;

Staff Recommendation
Staff supports a comprehensive HIV/AIDS instructional program. At the same time, staff recognizes the already crowded District curriculum and graduation requirements. However, this does not preclude the expansion of lessons and development of school-wide activities and programs to provide heightened student awareness.

VOTE: 7 ayes

7. Establish an Oversight Committee to insure development and implementation of HIV/AIDS education District-wide ~~at every school~~, and to monitor the implementation of these recommendations;

Staff Recommendation
Support in concept. The Superintendent has established staff line authority, through the Office of the Deputy Superintendent, to deal with operational and evaluation issues. The staff responsible include the Office of Instruction, Student Medical Services, Elementary District Offices, Middle Schools Unit and Senior High Schools Division.

VOTE: 6 ayes, 1 no, Mrs. Boudreaux

8. Work with the Commission on Sex Equity to develop materials that stress the power of females to say "No" to sexual advances ~~empowerment in sexual decision-making~~ (such materials may also be very appropriate for inclusion in the Parent/Community Outreach program~~, particularly when addressing women whose culture has left them unprepared for making changes in this area of their lives~~);

VOTE: 7 ayes

9. Develop a Parent/Community Outreach Program;

Staff Recommendation
Support in concept, especially in light of the new (1991-92) District organization structure, which includes a Deputy Superintendent of Human Resources, Parent and Community Services.

To the extent possible, the concepts involved would be pursued within existing resources. Staff would review any implementation concepts which have cost implications or negotiations requirements.

VOTE: 7 ayes

10. Explore extending health benefits to include the domestic partners of employees; (WITHDRAWN)

Staff Recommendation
That this item be withdrawn and reviewed in another established Board process.

11. Develop strategies to reach specific target groups ~~(groups are based on youth who are engaging in a variety of behaviors or are the victims of another person's behavior which may directly or indirectly increase their risk for HIV/AIDS)~~;

Staff Recommendation
Support as being in principle consistent with current practice. Additionally, support further study of the implementation specifics (page 33) and operational Health education programs that target at-risk populations.

VOTE: 6 ayes, 1 no, Mrs. Boudreaux

12. Continue working with lobbyists to advocate for passage of legislation which would facilitate HIV/AIDS education in schools and repeal of legislation which may obstruct such education; and (WITHDRAWN - Specifics will be brought back for action in the form of a motion)

POLICY ON AIDS/HIV PREVENTION EDUCATION

AIDS (acquired immune deficiency syndrome) and infection with HIV (human immunodeficiency virus), the virus that causes AIDS, are serious threats to the lives and health of young people in Massachusetts. HIV is transmitted through unprotected sexual intercourse and through blood-to-blood contact, such as that which occurs when intravenous needles are shared.

Due to prevalent patterns of sexual activity and substance abuse, many of our young people are at significant risk of infection with HIV. Our schools must play a major role in the concerted effort to stop the spread of the virus by helping students make healthy choices about their personal behaviors.

Further, as the number of individuals infected with HIV or diagnosed with AIDS continues to grow, we need to come to terms with these members of our local communities. Schools must also play a part in assisting students develop informed and compassionate responses towards those affected by AIDS/HIV.

Therefore, the Board of Education of the Commonwealth of Massachusetts urges local school districts to create programs which make instruction about AIDS/HIV available to every Massachusetts student at every grade level. These programs should be developed in a manner which respects local control over education and involves parents and representatives of the community.

The Board believes that AIDS/HIV prevention education is most effective when integrated into a comprehensive health education and human services program. Ideally, content related to various aspects of the AIDS/HIV epidemic (biological, social/historical, ethical, behavioral, interpersonal, statistical) will be spread across several curriculum areas, especially science, social studies, health, home economics, language arts and mathematics.

Current state law (General Laws Chapter 71, section 1) requires all schools to offer instruction in health education, including such topics as community health, body structure and function, safety and emotional development. We urge all school districts to develop with input from parents and community members, and to include as part of a comprehensive health education and human services program, an AIDS/HIV program which takes into consideration the following components of a complete AIDS/HIV prevention education program:

- policy - Appropriate local policies should be adopted regarding AIDS/HIV prevention education as well as the continued attendance of students and employment of staff who are HIV infected. Parents and representatives of the local community should be actively involved in the development and approval of these policies.

- parent and community education - The Board strongly suggests that schools play a leadership role in developing educational programs on AIDS/HIV for parents and community members who may reinforce the prevention message presented in the classroom.

- staff development - The Board believes that staff training is an essential component of an effective AIDS/HIV education program. In addition to faculty training, staff education should be directed to all school staff and should include basic information about AIDS/HIV, instruction in the use of recommended universal precautions when dealing with blood spills and training regarding relevant policies dealing with HIV-infected students and staff.

- curriculum and instruction - This instruction should be offered at all grade levels (including special education classes, programs, schools and residential facilities) in a developmentally, linguistically and culturally sensitive manner. Special efforts should be made to educate hard-to-reach and high-risk young people, particularly youth who are out of school, are drug-involved, are gay/bisexual or are members of communities disproportionately affected by the AIDS/HIV epidemic.

  Instruction in AIDS/HIV prevention should occur over multiple sessions, in a format which maximizes student interaction. This instruction should respect students' various learning styles. It should increase students' knowledge about AIDS/HIV, allow students to process their feelings about the AIDS/HIV prevention and should encourage the development of positive self-esteem and concrete decision-making, communication and behavioral skills.

  At the secondary level, and according to local decisions, AIDS/HIV education should be part of a more complete sexuality education curriculum. This curriculum should include information about sexually transmitted diseases and the value of both sexual abstinence and the use of condoms as disease prevention methods.

  The Board recommends that, when possible, persons living with AIDS/HIV be utilized in the classroom to impress upon students the reality of the epidemic and to build compassion and respect for persons affected by AIDS/HIV.

- student involvement - Students should be actively involved in AIDS/HIV educational efforts. Peer education programs and student-initiated projects are especially encouraged in order to develop a sense of students' responsibility for their own behaviors and for community members who are living with AIDS/HIV.

Approved April 24, 1990

ADDENDUM TO AIDS/HIV PREVENTION EDUCATION POLICY REGARDING CONDOM AVAILABILITY IN SCHOOLS

Due to the rising rate of HIV infection and other sexually transmitted diseases among adolescents, the need to address infection prevention in all ways possible is critical at this time. In Massachusetts, decisions about AIDS/HIV prevention education and sexuality education, like all decisions about curriculum and educational policy, are made at the school district level. In response, a number of school systems in Massachusetts have recently begun to consider making condoms available to students in secondary schools.

The Massachusetts Board of Education's Policy on AIDS/HIV Prevention Education states that AIDS/HIV prevention education should include information about sexually transmitted diseases, as well as the value of both sexual abstinence and the use of condoms as disease prevention methods. As school districts consider condom availability at the secondary level, the Board of Education makes the following recommendations as an addendum to the AIDS/HIV Prevention Education Policy:

We recommend that every school committee, in consultation with superintendents, administrators, faculty, parents and students consider making condoms available in their secondary schools.

We recommend that school districts consider varied routes through which students may acquire condoms, including the offices of school nurses and counselors as well as coin-operated vending machines located in men's and women's rooms. The school nurse or counselor's office would place condom availability in the context of a one-to-one professional relationship that could supplement the prevention education offered in the classroom. The vending machines would provide access to condoms in a manner that maximizes students' privacy and anonymity.

We recommend that school districts consider whether students at the secondary level need instruction about the correct use of condoms in order to increase understanding and effect behavior change.

Finally, we recommend that parent information accompany any efforts to make condoms available to students in schools. Parents would then be able to reinforce AIDS/HIV prevention messages at home, and place these messages in the context of their own personal values and religious traditions.

Addendum approved August 27, 1991

Policy, Philadelphia Board of Education, Approved 6/24/91

WHEREAS, the Board of Education is aware that adolescent pregnancy, sexually transmitted diseases and HIV infection are epidemic among school age youth; and

WHEREAS, a TaskForce, composed of medical, health care, advocacy, governmental, parental and employee organizations was convened to study the issues raised by adolescent sexual behavior; and

WHEREAS, the Task Force delivered its report on Adolescent Sexuality and the Role of School in the Prevention of Pregnancy, Sexually Transmitted Diseases and HIV Infection, including various policy options for the Board's consideration; and

WHEREAS, the Board of Education has conducted public hearings throughout the ity, at which the entire Philadelphia community, including parents, students,religious leaders and medical authorities, had an opportunity to, and did, respond to the Task Force report, showing a great deal of interest and concern for the issues and for the health and welfare of the young people of Philadelphia; and

WHEREAS, the Board recognizes that schools, iin concert with all segments of the Philadelphia community, have an obligation to promote a health lifestyle for all adolescents; be it

RESOLVED, that the Board of Education adopt policy statement number 123, Programs, Adolescent Sexuality.

No. 123

Section PROGRAMS

Title ADOLESCENT SEXUALITY

SCHOOL DISTRICT OF PHILADELPHIA

Date Adopted June 24, 1991
Date Revised October 28, 1991

Guide	123. ADOLESCENT SEXUALITY	Source
1. Purpose	1.1 The Board of Education reaffirms its policy to provide comprehensive human growth and development instruction to all public school students. In accordance with School District policy and state law, such instruction should be part of the public school program and should be shared by the public schools, home, and community. The primary purposes of such instruction are to promote more wholesome family and interpersonal relationships; to help young people understand their sexuality at all levels of development; and, to develop healthy habits and moral values regarding human sexuality.	Board of Education Policy #120, Rev. 12/17/90.
	1.2 The Board recognizes that the expression of human sexual behavior can be the source of many of life's most meaningful experiences as well as its most painful problems; and, the Board of Education firmly asserts that abstinence from sexual activity during adolescence promotes good health and a healthy lifestyle.	
	1.3 The Board of Education firmly believes that successful pursuit of the mission of promoting a healthy lifestyle for all adolescents depends upon the cooperation of a broad spectrum of the Philadelphia community, including schools, families, religious institutions, health care providers, social service agencies, businesses, government, and media.	

Policy Guides	123. ADOLESCENT SEXUALITY	
2. Authority	2.1 Pursuant to its authority under the Educational Supplement to the Home Rule Charter, the Board adopts the following policy objectives in order to promote a healthy lifestyle for all children.	Educational Supplement to The Home Rule Charter
	2.1.a. To enable and encourage students to abstain from sexual intercourse until ready to enter marriage or another mutually monogomous relationship.	
	2.1.b. To reduce high risk sexual behavior leading to teen pregnancy, sexually transmitted diseases and HIV infection.	
	2.1.c. To assure a safe, equitable and positive school experience for lesbian and gay students.	
	2.1.d. To assure that all programs and activities take into consideration the broad spectrum of ethnic and cultural diversities, as well as mental and physical disabilities.	
3. Delegation Of Responsibility	3.1 The Superintendent shall direct the development and acquisition of curricula which comprehensively promote healthy behavior and which shall be taught in all grade levels, pre-kindergarten through grade twelve. Such curricula shall focus on behavioral outcomes and will also utilize more innovative and effective methods to convey the message that abstinence is the most effective way of preventing pregnancy, sexually transmitted diseases and HIV infection; a voluntary parental education component, designed to enhance the frequency and effectiveness of parents' communication with their children; and, a mechanism for monitoring the efficacy of the curricula.	
	3.2 All school staff share in responsibility for understanding and promoting healthy adolescent behavior; therefore, the Administration will develop and maintain a comprehensive plan for staff education on adolescent health.	

3.3 The Superintendent is empowered to develop additional partnerships with health care providers that expand and maximize access to in-school comprehensive health care for all children, which will have a positive and lasting effect on the lives of the children of Philadelphia.

3.4 The Board believes that the effectiveness of the curricula to promote healthy lifestyles and to prevent pregnancy, sexually transmitted diseases and HIV infection is enhanced for sexually active students by facilitating their access to condoms outside of school. Toward that end, the Board supports the School District's involvement in city-wide efforts to maximize access to condoms.

3.5 The Board of Education directs the Superintendent to immediately initate the design of a pilot, educationally-based program, permitting the in-school availability of condoms and the counseling of students in the use of same, utilizing established non-School District health care and social service providers, in partnership with participating schools. Such programs shall commence not later than the Fall of 1991.

3.6 The phased-in pilot program of condom availability in schools shall apply only to students in grades nine through twelve. Moreover, every policy builds on already existing policy; and Policy #103 requires "equal opportunity for all students ...." — Board of Education Policy #103, Rev. 12/17/90.

3.7 A component of the phased-in pilot program shall be specifically for the education of parents, designed to enhance the frequency and effectiveness of parents' communication with their children about sexuality.

4. Recognition of Parental Authority

4.1 Parents or guardians of students in schools taking part in the phased-in pilot program shall have the absolute right to veto their child's or children's participation in the program.

5. Evaluation and Research

5.1 The Board of Education directs the Superintendent to develop program evaluation criteria that will be used to evaluate the efficacy of all programs initiated under this policy, as well as their impact on adolescent sexual behavior.

5.2 The Administration will monitor the phased-in pilot program and such other programs so initiated; and, it shall apply those program evaluation criteria developed to evaluate program efficacy.

5.3 The Superintendent shall report to the Board of Education on such evaluations at such times as requested by the Board; and, prior to implementation of the program evaluation criteria, the Administration shall fully apprise the Board of the structure and objectives of same.

EXCERPT FROM POLICY, ADAMS COUNTY SCHOOL DISTRICT #14 BOARD OF EDUCATION, APPROVED 8/23/88

DISEASE TRANSMISSION PREVENTION

In attempt to make reasonable accommodation and promote responsible decision making for individual students who have decided to engage in sexual activity and/or other high risk behaviors, which could bring exposure to sexually transmitted diseases such as AIDS, Chlamydia Infection, Gonorrhea, Herpes, Human Pappillomavirus, and Syphilis,the school district shall make available the opportunity for students to visit with medically supervised professionals from the Commerce City Community Health Service or the Commerce City Family Health Center to be counseled about sexuality decision making, disease transmission and prevention methods. Distribution of disease prevention material shall be done under the auspices of a licensed physician and only when appropriate counseling has taken place so the individual is thoroughly familiar with the complications associated with high risk behavior. Parents wishing to withhold any sexuality counseling or referral may request such by signing the appropriate permission withholding form.

CPO 1993--ATTACHMENT II.D.6

HIV/AIDS POLICY IN HAWAII:

1992 REPORT AND RECOMMENDATIONS OF THE

GOVERNOR'S COMMITTEE ON AIDS

January 1992

HAWAII STATE

GOVERNOR'S COMMITTEE ON AIDS
COMMITTEE MEMBERS AND PROXIES

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*John C. Lewin, M.D.	+Diane Hirsch, Ph.D.
*Dorothy Ono, R.N., M.P.H.	+Liberato Viduya, M.Ed.
*Warren Price, J.D.	+Charlene Young, M.P.H.

* Governor's Committee on AIDS Members
\+ Governor's Committee on AIDS Proxies

HIV EDUCATION FOR CHILDREN AND YOUTH

POLICY STATEMENT:

The Governor's Committee on AIDS recommends that HIV/AIDS education, outreach and risk reduction efforts be directed toward all children and youth.

RATIONALE:

As of August 1991, 3,199 cases of AIDS among children under 13 years of age were reported nationally through the CDC. By the same date, there were 715 reported AIDS cases among those 13-19 years old, and 7,549 cases in the 20-24 year old category. Thousands more are infected by HIV, but not yet diagnosed with AIDS. Because of the long HIV incubation period, many young adults aged 20 to 29 years with AIDS were likely infected as teenagers. Hawaii's youth may be at exceptional risk because some are engaged in high-risk behaviors, both with their peers and with the state's large transient tourist and military populations.

Younger school-aged children have most often been infected by transmission of HIV perinatally or through the receiving of blood products. Many children and youth may encounter classmates, friends and family members infected with HIV.

Behaviors which particularly put teenagers at risk for HIV infection are unprotected sexual intercourse and the use of alcohol and other substances. Data indicates that 42% of Hawaii's teenagers report having had sexual intercourse by the tenth grade. Approximately 160 gonorrhea cases in Hawaii in 1990 were reported in youths 15 to 19 years. Clearly, sexual experimentation is common during adolescence and includes both heterosexual and homosexual encounters.

Experimentation with drugs and alcohol among Hawaii's teenagers is widespread. Needle-sharing during intravenous and intramuscular drug use (including steroid use among high school athletes) and tattooing pose a direct risk of HIV infection. Equally dangerous, however, is alcohol and other drug use which impairs judgement and reduces impulse control when sexual and other potentially risky behaviors are present.

Relatively few adolescents under the age of 19 years (approximately 450) sought HIV counselling and testing services offered by the Department of Health (DOH) in 1990, despite the high rate of risk-taking behaviors among Hawaii's teenagers.

The State of Hawaii has developed a comprehensive AIDS curriculum for grades K through 12. As with other sexuality curricula, however, effectiveness is related to the teacher's comfort and expertise in the area of human sexuality. HIV/AIDS information should be presented in the broader context of family life curricula, which includes the varieties of human relationships and helps to develop negotiation skills.Some teenagers in Hawaii clearly have become

infected with HIV because they lacked knowledge about the virus and the skills to protect themselves from it. The current curricula in Hawaii's public and private high schools have little or no relevance for gay, lesbian, bisexual, or transsexual youth. These young people may drop out of school or even leave home in the search for experiences and individuals to which they can relate, or which can validate and confirm their sexual orientation.

GOAL #1:

The State of Hawaii will provide age-appropriate HIV/AIDS education through a comprehensive pre-school through 12th grade health education curricula by June, 1993.

SPECIFIC ACTIONS TO ACHIEVE GOAL #1:

(a) Assure that all HIV/AIDS-related curricula in state public schools have an adequate and permanent funding base.

(b) Assure that all HIV/AIDS-related curricula in state private schools have an adequate and permanent funding base. Encourage these schools to finance this funding through private sources.

(c) Encourage DOE and DOH to continue to evaluate and analyze the results of the DOE's HIV/AIDS education program in the schools. All private schools should be encouraged to access the program's findings and recommendations.

(d) Update needs assessment based on identification of current problems, issues and concerns.

(e) Update HIV curricular content and format of K-12 health education programs in all public and private educational settings.

(f) Assure that all HIV curricula address the realities of adolescent sexual and substance-using behaviors, and that students receive this information before they engage in high risk behaviors. Make condoms available to students in Hawaii's intermediate and high schools through the schools' health nurses and aides in the context of a comprehensive health education curriculum which provides information on sexuality, abstinence, condom use and other topics.

(g) Integrate HIV/AIDS and other curricular materials into existing health education programs, with specific emphasis in the area of family life education, the development of decision-making skills and substance use.

(h) Provide comprehensive and ongoing HIV curriculum training to health and other resource teachers responsible for AIDS education so that they are knowledgeable and comfortable in the areas of HIV and adolescent risk behaviors.

GOAL #2:

To reduce the potential spread of HIV/AIDS among children and youth (0-21 years) who may not be reached through the school system, the State of Hawaii shall require aggressive HIV/AIDS/STD and other risk assessment of this target group and shall design and implement appropriate HIV/AIDS education to meet their specific needs.

SPECIFIC ACTIONS TO ACHIEVE GOAL #2:

(a) Secure education and risk reduction funding for public and community-based programs to target groups at risk (i.e., alcohol/drug users, sexually active youth, gay/lesbian/bisexual/transsexual youth, runaway and homeless youth, and those youth residing in group homes, detention facilities and other restricted or sheltered settings) and those who attend probationary educational programs.

(b) Develop HIV/AIDS-related programs to meet the specific experience and needs of gay/lesbian/bisexual/transsexual youth.

(c) Require that all state-licensed programs which work with at-risk children and youth integrate comprehensive HIV risk reduction information into their programs. Strongly encourage non-state programs to do the same.

(d) Require that all state-licensed programs (i.e., private day care, foster care, emergency shelters and other programs) which work with at-risk children and youth provide regular comprehensive HIV/AIDS training to administrative and line staff.

(e) Establish and coordinate links among State, County and private community-based agencies to facilitate increased communications regarding consistency and adequacy of HIV/AIDS-reduction programs for out-of-school youth.

(f) Provide and disseminate supportive educational materials and services for those parents, foster parents, guardians, babysitters and others who may be caring for HIV-infected infants, children or youth.

GOAL #3:

The State of Hawaii will provide appropriate HIV/AIDS education for youth aged 18-21 years who are enrolled in community-based education programs, such as the University of Hawaii and its satellite colleges, technical/vocational schools, other educational facilities of higher learning, night schools, and others.

SPECIFIC ACTIONS TO ACHIEVE GOAL #3:

(a) Establish an adequate funding base for HIV/AIDS education which is provided to those 18-21 years who are in public community-based education programs.

(b) Establish an adequate funding base for HIV/AIDS education which is provided to those 18-21 years who are in private community-based education programs.

LEAD AGENCIES: Department of Education, Department of Health, Department of Human Services, Judiciary, Office of Youth Services, Office of Children and Youth, University of Hawaii and HIV-related community service organizations.

CPO 1993--ATTACHMENT II.D.7

SAN FRANCISCO UNIFIED SCHOOL DISTRICT

Policies About Health Education, Condom Availability in a Clinic Setting, and Condom Availability in a Non-Clinic Setting

Approved by the Board of Education on 10/8/91

Policy #1 Health Education

A comprehensive health education program with sequential lessons facilitating mastery of age-appropriate concepts that enable students to adopt health-promoting behavior will be taught to students in grades K-12:

1) by classroom teachers in grades K-5 (including specified special education and bilingual classrooms);
2) within the content of specified science, physical education, bilingual or special education classes in grades 6-8 in middle schools; and
3) in required health courses, and specified science, social studies, bilingual, special education or other courses in grades 9-12 in high schools.

The instructional materials related to sexuality will be previewed by the Family Life Education Advisory Subcommittee to assure that the content is age-appropriate, culturally sensitive, language specific, inclusive of the needs of groups within the student population and reflects the needs of this community. Classroom presentations about human sexuality presented by individuals who are not credentialed District employees and representatives of public and private community agencies will also be reviewed by members of the Family Life Education Advisory Subcommittee prior to use in the classroom. Membership of the Family Life Education Advisory Subcommittee will include a minimum of three parents who currently have students enrolled in the School District and are representative of the ethnicity of the student population.

As required by California Education Code (51550), if the instruction addresses human sexuality, parents/guardians will be notified prior to the instruction, given the option of excluding their students from the instruction and be given an opportunity to review the materials to be used. Also as required by California Education Code (51551), instruction about human sexuality will emphasize that the 100% safe way to prevent pregnancy and sexually transmitted diseases is to abstain from sexual intercourse (abstinence).

Individuals and agency representatives who make classroom presentations about human sexuality and sexually transmitted diseases will comply with California Education Codes and School District policies that include prior review of the Family Life Education Advisory Subcommittee, prior notification of parents/guardians, making instructional content and materials available for parent review, and obtaining prior approval of designated District and school site personnel. Classroom teachers who are hosting guest speakers will 1) preview the presentation and/or material to be used; 2) obtain prior school site administration approval in the same manner done with all classroom visitors; 3) when the presentation is about human sexuality, send prior notification to parents/guardians; 4) when requested by the parent/guardian, exclude students from the instruction and provide an alternative learning activity; 5) remain in the classroom when guest presenters are not School District employed credentialed teachers; 6) maintain order in the classroom and 7) provide discipline when needed.

Staff development for teachers who are given the responsibility for instruction and instructional resources will be provided by the health education staff of the Health Programs Office. Teachers who do not have credentials required by the State of California to teach health education are mandated to participate staff development activities. Teachers who choose not to present the lessons related to human sexuality will be given that professional option. Other arrangements will be made to assure that all students have the opportunity to have the instruction.

By October 15, 1991, lessons about HIV infection prevention for students in grades K through 12 and based on a scope and sequence of age-appropriate concepts will be completed by the staff of the Health Programs Office. The lessons that deal with sexuality will be reviewed by the Family Life Advisory Subcommittee to assure that the content is age-appropriate, culturally sensitive, language specific, inclusive of the needs of groups within the student population and reflects the needs of this community. By November 15, 1991 the HIV infection prevention lessons will be presented to the Board of Education for approval.

Upon approval of this policy, the planning process for the remaining components of comprehensive health education will be accelerated with the goal of having a complete instructional program in place by the beginning of school year 94-95.

Policy #2 Condom Availability in a Clinic Setting

The Board of Education will permit making latex condoms and other forms of contraception available to high school age students a clinic setting that is staffed by licensed health professionals on a high school campus in a pilot program. The implementation plan will include an evaluation component.

Recognizing that parents/guardians have the primary responsibility for educating their children about sexually transmitted diseases (including HIV infection), teen pregnancy and the consequences of drug use, parents/guardians of students enrolled in the school where condoms and/or other forms of contraception are available will be involved in the developing the implementation plan. Using California Education Code 51550 as a guideline, parents/guardians will be notified prior to the implemenation of the pilot program and parents/guardians will have the opportunity to exclude their students from participating in the program. Further, parents will be offered education and given access to educational materials that will assist them in communicating with their students more effectively.

The School District will seek funding for the pilot program that does not further diminish resources available to address the educational and health needs of school-age children and prevent spread of infectious diseases (in addition to sexually transmitted diseases) in the school setting among students and staff.

Immediately upon approval of this policy, the planning process for the pilot program in a clinical setting will begin with the goal of implementation during the fall semester of school year 91-92. The planning process will include but not be limited to: officials of San Francisco Department of Public Health, San Francisco Unified School District, school site personnel designated by the principal, students, parents with students enrolled in the school, and staff of the clinic. The implementation plan will be presented to the Board of Education for final approval before implementation.

Policy #3 Condom Availability in a Non-Clinic Setting

The Board of Education will permit making latex condoms available to high school age students in a non-clinic setting on a high school campus in a pilot program. The pilot program will include an evaluation component.

A pilot program will be designed to include parent involvement in the planning process, recognizing that parents/guardians have the primary responsibility for educating their children about sexually transmitted diseases (including HIV infection), teen pregnancy and the consequences of drug use. Using California Education Code 51550 as a guideline, parents/guardians will be notified prior to the implemenation of the pilot program and parents/guardians will have the opportunity to exclude their students from participating in the program. Further, parents/guardians of students enrolled in schools where condoms will be made available will be offered education and given access to educational materials that will assist them in communicating with their students more effectively.

The School District will seek funding for the pilot program that does not further diminish resources available to address the educational and health needs of school-age children and prevent spread of infectious diseases (in addition to sexually transmitted diseases) in the school setting among students and staff.

Immediately upon approval of this policy, the planning process for a pilot program in a non-clinical setting will begin with the goal of implementation during the spring semester of school year 91-92. The planning process will include but not be limited to: officials of San Francisco Unified School District, appropriate community agencies, school site personnel designated by the principal, students, parents with students enrolled in the school, and staff of the Health Programs Office in the District. After review of the Family Life Education Advisory Subcommittee and the Superintendent's School Health Advisory Committe, the implementation plan will be presented to the Board of Education for final approval before implementation.

Address questions to Dr. Beverly Bradley, Supervisor of Health Programs
1512 Golden Gate
San Francisco, CA 94115
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Editorial: Baltimore, October 25, 1990

The Evening Sun

BALTIMORE, HOME DELIVERY: 25 CENTS (in m

Tackling teen pregnancy

The newest figures are two years old, but they are ominous nonetheless: In 1988, more than 5,500 Baltimore city teen-agers became pregnant; over 3,000 gave birth. And there is little reason to suspect the numbers have changed very much since. There are perhaps as many reasons for teen pregnancy as there are teen-agers who become pregnant. But the underlying problem is this: These adolescents are either ignorant about birth control, or they don't know how to get it and use it.

Now the city Health Department has embarked on a wise, albeit controversial, course: It has begun distributing birth control pills and condoms through on-site health clinics at seven city schools. The idea comes from a landmark study by the Johns Hopkins University done in the early '80s in which students could get professional counseling at school and medical and contraceptive services at nearby clinics. After three years, the pregnancy rate in the participating schools dropped 30 percent, and the median age of a girl's first sexual encounter rose from 15½ to 16.

Sixteen is still vulnerably young; and it would be wonderful if teaching adolescents to "just say no" would be enough to deter sexual activity. But in a city that has one of the highest teen-age pregnancy rates in the nation, that is wishful thinking. The fact that contraceptives will be given *only* to those students who are already sexually active indicates that parents have already had their chance at moral suasion — and failed.

On the other hand, the Hopkins study made pretty clear that access to contraception does *not* encourage sexual precocity any more than making it difficult for adolescents to get contraceptives fosters abstinence. In practical terms, giving teen-agers counseling, medical care and birth control serves simply to lower the teen pregnancy rate. That's a goal worth pursuing. Now that the Health Department has taken the first bold step it should take another, and expand the program to other city schools too — notwithstanding the rejection, by the closest of votes, of a similar program in rural, conservative Talbot County yesterday.

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Editorial: Baltimore, November 21, 1990

THE SUN

BALTIMORE, MARYLAND HOME DELIVERY: 25 CENTS

Birth Control in City Schools

The disclosure that Baltimore's health department dispenses birth control pills and condoms at seven city schools has upset some parents and clerics. Schools are supposed to educate, not pass on moral judgments, they contend, adding that dispensing birth control not only crosses that line but sends the dangerous message that teen sex is permissible.

Such concerns are understandable. Changing mores, together with alarming increases in teen pregnancies and venereal disease, are frightening realities. Equally frightening is institutional intervention in moral decisions.

Proponents argue that the issue is health, not morality, that the aim is to temper the fallout from teen sex. That a problem exists is the middle ground on which both sides can agree. Consider these troubling statistics: the rate of birth to teen-aged girls, on the decline after 1973, began climbing again in 1986. The number of births to girls ages 15 to 17 rose 10 percent from 1986 to 1988. That year, Baltimore led the nation in babies born to teens. Last year, nearly a third of the city's gonorrhea cases involved teen-agers.

It is against these worrisome numbers that birth control in school-based clinics must be weighed. Certainly the notion strikes emotional chords in parents anxious to protect their children from the folly of premature sex. Many favor urging abstinence — sound advice, but inadequate without information on protection.

Will dispensing condoms encourage teen-age sex? A Johns Hopkins University study done in the early '80s points to the contrary: a school-linked clinic that distributed contraceptives caused a 30 percent drop in the pregnancy rate and an actual *decrease* in sexual activity.

It is important that the value of this program not be lost in emotionally charged, erroneous perceptions. No one, in fact, is proposing that teachers pass out condoms as they would composition books. No one is suggesting that youngsters be given means of birth control without proper counseling — including the discussion of abstinence. The health department simply wants to make these available to teens at clinics in the schools. These same clinics since 1985 have not only counseled sexually active city students but have prescribed contraceptives that would ordinarily be picked up at clinics outside the schools.

Is dispensing birth control at school health clinics really any more objectionable than referring youngsters to a family-planning clinic? The availability of information — and access — to birth control seems to be a sensible response to teen sexuality. Assistance from health care professionals does not create the problem. It may be one of the solutions.

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Editorial: Boston, February 20, 1990

A health plan for the schools

Understandably, the call to make condoms available to Boston teen-agers at their schools – where they would be given out by health professionals, not teachers – as a means of preventing AIDS is the attention-grabber. In the climate of Boston politics, the question becomes how this will fit with Mayor Flynn, who has previously opposed condom distribution in the schools.

But the proposal of Judith Kurland, Boston's commissioner of health and hospitals, goes far beyond condoms. Her plan needs to be supported not only to help adolescents who are known to be sexually active and at high risk for AIDS, but also to deliver health services to inner-city adolescents who by every measure sorely lack them.

Actually, her plan is not new. Similar proposals have been made by City Councilor Thomas Menino and former state Public Health Commissioner Deborah Prothrow-Stith.

What is new is proof of how much more vulnerable low-income youngsters – especially African-Americans and Hispanics – are to AIDS, sexually transmitted diseases, pregnancy and violence.

Of the 56,000 teen-agers living in Boston, one-third of those in middle school and half of those in high school are sexually active. The vast majority do not regularly practice safe sex.

State health officials report that teen-agers and young adults are contracting sexually transmitted diseases at the highest rate in 40 years. By overwhelming numbers, African-American and Hispanic adolescents are being hardest hit.

Girls in these ethnic groups develop gonorrhea 50 times more often than their white counterparts. In African-American and Hispanic boys, the frequency of gonorrhea is 100 times higher than that of their white counterparts. And it is now clear that infection with the classic sexually transmitted diseases forecasts infection with AIDS.

But Kurland's plan would do more than educate students about AIDS and STDs and disseminate condoms and contraceptives – unless parents object to their children having them.

It would enlist techniques whereby youngsters can protect themselves from physical danger and from the many health crises they face. They would be taught to deal with peer pressure and to delay having sex until they are older, as has been demonstrated elsewhere.

Although Kurland's plan emphasizes that abstinence is the only sure protection against AIDS, it recognizes that condom use by sexually active teen-agers is the next-best safeguard. AIDS education would also be given to teachers and parents.

In collaboration with the state Department of Public Health and the Boston School Department, hospitals, health clinics, community health centers and health maintenance organizations, general health services would be brought onto school premises.

Mayor Flynn asked Kurland to develop this plan, and it won the support of School Superintendent Lois Harrison-Jones. Now, he should enact it in the health interests of the city's children.

Reprinted courtesy of *The Boston Globe*.

Editorial: Boston, June 13, 1992

School clinics and condoms

The city is moving slowly but, we hope, inevitably toward the establishment of comprehensive health clinics in its public high schools, facilities that, along with proper counseling, would make condoms available to students who seek them.

The high rates of sexual activity among teen-agers, the terrifying reality of AIDS and the evidence that sexually active teen-agers use condoms far too infrequently have been widely understood for years. Yet, the conservative cast of the city's power structure when addressing social issues has blocked efforts to make condoms available to high school students.

Those efforts suffered a setback several months back when Mayor Flynn asserted that the distribution of condoms might actually promote sexual activity and therefore the spread of AIDS.

Thankfully, he backed away from the position a couple of days later and has supported the development of a plan by the health and hospitals commissioner, Judith Kurland, to establish clinics run by her department in the city high schools.

While Flynn will almost surely stick to the position that abstinence is the way to prevent the sexual transmission of AIDS – a view that is correct on its face but not responsive to the realities of teen-age sexuality – he apparently is comfortable with the proposal that health department personnel, rather than school officials, would be responsible for any in-school condom distribution. The use of health personnel also apparently satisfies Superintendent Lois Harrison-Jones, who has opposed condom distribution by school workers.

There will be more political skirmishing before it is over. Conservative city councilors will doubtless try to block the effort. The School Committee must vote for the establishment of the high school health clinics, a question that will be entangled with the condom issue.

But if common sense prevails by next fall, Boston public high school students will be able to receive comprehensive professional counseling on violence prevention, on drug abuse, and on sexuality and AIDS – and, in appropriate circumstances, condoms when they request them.

Reprinted courtesy of *The Boston Globe*.

Editorial: Philadelphia

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Wednesday, June 26, 1991 Page 10-A

EDITORIALS

Sex and schools

Confronted with competing strategies, the school board gives both a try

Two facts for today: For every Philadelphia high-schooler who has never had sex, there are two who have. Second, of the boys who do have sex, half never use a condom. Considering the risk of pregnancy and disease inherent in those facts, some people have urged the public school system to better promote abstinence, while others have urged it to provide free condoms. This week, the Board of Education decided — wisely — to do both.

The initiative has something for everyone to dislike. The anti-condom crowd is complaining that the abstinence message won't be credible, while the pro-condom crowd knocks the plan as too gradual and restrictive. Obviously, the plan reflects political compromise on an emotion-packed issue, but if implemented well it just might help. It is a promising departure from the school district's past practice of virtually ignoring the problem.

In matters such as this it often matters more how something is done, rather than simply what is done. Condoms supposedly will be provided only in conjunction with counseling, not handed out in gym class while kids exchange high-fives, and this should reduce the possibility that making them available will undercut the admonitions on abstinence. Parents who don't want their kids to have condoms can so stipulate. (The complaint that they'll get them from their friends is silly. Condoms are not hard to come by at present. Anyone who wants them can already walk into any drugstore and buy them.)

Some activists on this issue have criticized the slow timetable. (The program will start this fall in a handful of schools around the city.) But by phasing this in rather than trying to do it all at once, the school system will have a better chance of doing a good job of coordinating the introduction of contraceptives with the other two basics: better counseling and better teaching about responsible behavior. (It also can back off if the program proves ineffective.) The criticism about the fact that the condoms will be available only for ninth graders and up is more substantial. Sexually active younger children should also get them.

From the jeers at the board's meeting on Monday, it's clear that there remains a lot of disdain and mistrust between the warring factions on this issue. But it's also true that in its overdue bid to save lives the Board of Education has taken sensible ideas from both sides.

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Editorial: Washington, May 13, 1992

The Washington Post

AN INDEPENDENT NEWSPAPER

The Mayor's Response to AIDS

WE PRINT on the opposite page today an article by at-large D.C. Council member Linda Cropp on the topic of condom distribution in the city's public high schools. Mrs. Cropp, herself a parent of two teenagers, has confronted this difficult question before as a member of the D.C. school board. She revisits the issue now in response to Mayor Kelly's aggressive plan to tackle the city's AIDS epidemic through the distribution of condoms in high schools and jails, and a limited clean-needle exchange program for drug addicts. As with Mayor Kelly, Mrs. Cropp sees the growing crisis—which has made this city the nation's AIDS capital—as a life-or-death issue. Consequently, the mayor and Mrs. Cropp come down on the side of distribution. Despite some qualms of our own, that is where we find ourselves too.

We understand the uneasiness of those parents, clergy, educators and others who care deeply about children and who fear that the distribution of condoms to unwed school-age kids will encourage and imply approval of casual sex. Comparable misgivings might well apply to the clean-needle exchange program as far as the implied acceptance of drug use is concerned. Those proposing the escalation of the actions against AIDS don't expect or believe condoms will cause promiscuity or clean needles will promote more drug use. For them, and for us, the prevalence of AIDS and the rise in HIV infections have advanced beyond the point where action on the part of those responsible for the well-being of this part of the population can be limited to arguing for sexual restraint.

According to a federal study conducted by the National Cancer Institute, the Centers for Disease Control and the Walter Reed Army Institute of Research, one in every 87 District men aged 20 to 64 has the HIV infection. And while a leveling off of new AIDS cases is projected for the rest of the nation, the number is expected to increase dramatically in the District—by 34 percent in 1994. By that time, AIDS cases among IV drug users are expected to equal or outstrip those among gay and bisexual men. And with a teenage population that the CDC says is 75 percent sexually active—hence extremely vulnerable to AIDS—Mayor Kelly made something of a point when she said last year, "I don't know how many statistics it's going to take . . . before we'll figure out we're not doing something right."

The mayor's program has been launched with the support of School Superintendent Franklin L. Smith and several members of the council and school board. Their help will be required if her plans—which include aggressive educational and counseling programs as well as AIDS prevention and testing campaigns in churches, community centers, schools and jails—are expected to work. But doing nothing is the surest way to keep the AIDS death toll on the rise.

(c) The Washington Post.

Editorial: Washington, April 14, 1992

The Washington Post

AN INDEPENDENT NEWSPAPER

AIDS Ostriches

SEX. Condoms. Contraceptives. There they are, the three little words the government seems determined to avoid in its so-called public education program on AIDS. In the past two weeks startling figures about teenage sexuality and the rising rate of AIDS and sexually transmitted diseases in this group have been published. Yet the government's response seems to be "Here comes trouble. Let's put our heads in the sand, and maybe it will go away."

In a misguided attempt to avoid offending anyone with straight talk, bureaucrats have shied away from discussing the very things that might protect teenagers and others from this fatal disease. A proposed ad campaign drawn up for the Centers for Disease Control was so severely edited that the words "sex" and "condom" were excised entirely. And a book on child care that was to be mailed to 275,000 families of federal workers covered by Blue Cross-Blue Shield was reprinted so that a chapter on adolescent sexuality and contraception was eliminated. This isn't policy, it's priggish nonsense.

In a report issued last week by the House Select Committee on Children, Youth and Families, some Republican members defended the administration's reluctance to come to grips with difficult facts by saying that sexual abstinence and strengthening the family, not government-sponsored information programs, were the answer to teenage AIDS. The belief that these two approaches are mutually exclusive is difficult to understand. They are complementary. Clearly parents should take the lead in transmitting values, setting standards of behavior and providing information on sex to youngsters. That was specifically encouraged in the now-junked CDC ads and in the censored book aimed, after all, at parents. But in the real world, teenagers also need information that parents hope they won't have to use.

Anyone with a 16 year-old driver in the family knows that he or she should be told: "First, you are too young to drink so never, never have a beer. Second, absolutely never drink too much. And finally, if perhaps you do, do not even think about getting behind the wheel of a car. Find a friend, stay where you are. Or call us and we will come and get you." Does it ever enter anyone's mind that this set of directions, including what must be done if the parents' best advice is ignored, is irresponsible? Will it lead kids to get drunk, or will it merely create a chance of saving them from disaster if they do?

By the age of 20, 68 percent of females and 86 percent of males are sexually active, which means that they are at risk for AIDS. Teenagers need specific information about how to avoid exposure, and the government is tiptoeing around this obvious fact, pretending that ignorance can't kill.

(c) The Washington Post.

CHAPTER THREE

WORKING WITH THE COMMUNITY

One of the most challenging hurdles to preventing adolescent HIV/AIDS and pregnancy is the reluctance of officials and communities to accept the seriousness of the threat and the urgent need for a coordinated, public response. While frank discussion of and media attention to these sensitive issues is increasing, all too often HIV and sexually transmitted disease (STD) infection and adolescent pregnancy are still perceived as "someone else's problem" – another city, another group, another family.

A school board or health department may pass a condom availability policy without an extensive educational effort, but the policy is likely to be short-lived unless community concerns are adequately addressed. An informed public is less susceptible to misinformation and rhetoric.

In many communities, the impetus for a condom availability program has come from grassroots groups working on adolescent HIV/AIDS and pregnancy issues. Often coalitions form and spend considerable time educating the community and public officials about the problem, and condom availability as part of a solution, before school boards are willing to take an official position.

In response to the increased public awareness and pressure, school officials often appoint a task force or committee to make recommendations upon which the school board votes. Coalitions are usually represented on the task force, where they continue to play an important role in educating the community and helping demonstrate popular support for condom availability.

An understanding of how coalitions form and function is important for anyone seeking to establish a new and controversial program. This chapter is directed to community organizers concerned with HIV/AIDS and adolescent pregnancy, but also should be read by school and health officials who are seeking community support for their initiatives. It outlines strategies for reaching and involving community members in building support, designing an education campaign and responding to opposition.

I. BUILDING COMMUNITY SUPPORT

Policymakers want to know that the decision to adopt a condom availability plan is supported by the community. They want to hear directly from their own constituency – parents, teens, community leaders, youth-serving agencies (YSAs) – before making the politically risky decision to support condom availability in schools. In the face of potential conflict, community support must be more than tacit; it needs to be visible. In almost every community, some level of community support and organizing is needed. Coalitions traditionally fill this need.

A. Organizing a Coalition for Advocacy

A coalition is an alliance of groups pursuing a unified goal through coordinated strategies and pooled resources. A coalition may be initiated by community interest groups, school leaders or public health officials seeking community support for their programs. Sometimes the interests of policymakers and local coalitions coincide and they work in tandem. School or public health officials may provide leadership in bringing groups together and guiding strategy decisions, but they usually are not members of the advocacy coalition.

Coalitions have offered significant support to school and health officials taking the lead in making condoms available in schools. Many existing condom availability programs exist only because coalitions effectively organized support for the program and made the issue safe and compelling for political leaders.

Coalitions can provide invaluable assistance in community education and advocacy because they:

- provide visible signs of community support needed by policymakers
- bring people and resources together from all sectors of the community
- help increase production and quality of work
- allow people and groups to contribute their unique expertise
- educate and mobilize coalition members' constituents
- provide services and resources for program operations
- allow participants to identify genuine concerns and engage in problem-solving as a group.

An effective coalition is not easy to maintain. Each member will have its own agenda, style of leadership and "personality." It is important to remember that in a coalition:

- logistics are more complicated
- all members must be heard and should share in decision-making
- it is more difficult to achieve consensus
- some tasks may take longer
- credit as well as blame is shared.

Some communities – particularly large cities like New York, Washington, D.C. and San Francisco – have powerful constituent groups that frequently work in coalition to achieve a specific policy goal. Citizen groups in smaller cities or communities may be less experienced in joining forces to exercise power and may coalesce more slowly.

If a government agency staff member – whether school district or health department – becomes identified with an advocacy coalition, she or he could jeopardize the public's perception of that department's objectivity and limit the ability of the department to provide leadership within the broader community. At the same time, because coalitions operate by consensus, the participation of school and health officials accountable to the general public could constrain coalition advocacy decisions. Thus the relationship between a coalition and officials should be carefully considered.

Public officials must also realize that the coalition may sometimes disagree with their decisions. There will always be legitimate disagreements, many of which can be resolved. Regular communication and open responses to concerns can help avoid misunderstandings and conflict. On the other hand, convincing public officials to support a condom availability program may be the coalition's first goal. If they resist the program, officials are likely to be targets of coalition activity, rather than partners.

GUIDELINES FOR EFFECTIVE COALITIONS

Develop a statement of purpose and goals. An organization's membership in a coalition is confirmed when the group endorses the statement of purpose and goals which together guide coalition activity. (See Attachment E.1 for a copy of the Washington, D.C. Condom Availability Coalition's endorsement form.)

The **statement of purpose** can be broadly worded to reflect the philosophy of the coalition and permit a wide range of groups to participate. For example: "To support comprehensive HIV/AIDS education and pregnancy prevention strategies that include teaching about abstinence and skills to delay sexual intercourse, and making condoms available to sexually active adolescents."

The **goals** should be specific and achievable: "the adoption and implementation of a condom availability program for grades nine through 12 in the public school."

Establish a structure and leadership roles. Coalitions are most effective when all members have a voice and know they will be heard. Creating this sense of mutual involvement, however, does not negate the need for organized leadership and structure.

Coalitions should:

- Choose a chairperson and clearly define his or her responsibilities. It often helps to have co-chairs whose skills complement each other and who represent organizations willing to commit significant time and/or resources to coalition efforts. Roles can be shared or rotated.
- Create a leadership team that includes representatives of major interest groups. A homogenous team will have difficulty providing effective leadership on issues related to AIDS and teen pregnancy.
- Appoint a spokesperson for the coalition (who may or may not be different from the chairperson) and agree on a process for handling media requests and opportunities.
- Share responsibilities for the work through task forces or committees. Task forces or committees might be permanent or be appointed to complete a specific project. Define committee responsibilities and the decisions that can be made without the broader coalition.

Be explicit about how decisions will be made. Coalitions often make decisions by consensus. This does not mean that everyone has to agree on everything. If that were the case, no decisions would ever be made. Rather, it means that a majority agrees and that no group feels so strongly opposed that it would veto or publicly oppose the effort. Decide what will happen if consensus cannot be reached. Some groups vote on at least some issues.

- Some decisions can be made by the coalition leadership team, but others are so important or sensitive that the entire membership needs to be involved. Determine in advance what issues must come before the entire coalition and how the coalition will make decisions quickly.

(Continued)

GUIDELINES (Continued)

Maintain up-to-date mailing, phone and fax lists of coalition members and key contact persons. Keeping coalition members informed maintains their trust, interest and involvement. It also minimizes misunderstandings and identifies points of disagreement before they become problems. Coalition members should receive minutes from meetings, updates, articles and information on future events. Advance notice encourages members to participate in important discussions and decisions.

Hold regular meetings. Meetings should be held frequently enough to respond to current situations, and can be scheduled weekly, bi-monthly or monthly. Hold meetings at a convenient time and location; start and end on time. Consider whether meeting times should rotate between day and evening hours and locations.

Establish a coalition identity. A coalition is more than the sum of its parts. To establish identity and generate excitement for the goals, members need to see how they fit in. Letterhead stationery or a frequently updated member list fosters ownership among members and the respect of those who receive coalition communications.

Expand your base. The number and range of groups the coalition attracts reflects its success. In fact, political leaders will judge the strength of the cause by the coalition list – both who is on it and who is missing! Approach education, health, religious, civil rights, gay and lesbian, professional and women's groups, youth-serving and social service agencies, unions, civic and neighborhood associations.

Develop materials for distribution. Compile a packet of materials that can be distributed throughout the community and to the media. The packet might include:

- national and state statistics on rates of adolescent sexual activity, pregnancy and HIV/STD infection (see Chapter 1)
- a local needs assessment report (see Chapters 5, 7 and 8)
- information on condom availability programs across the country (see Chapter 2)
- a list of national organizations supporting school condom availability (See Attachment III.B)
- the list of coalition members
- the coalition's purpose and goals
- favorable press coverage of the coalition or other condom availability programs
- articles about teens (or people infected in their teens) living with HIV.

Monitor planning and implementation of the program. Once a policy has been adopted, the expertise of coalition members can be useful to the school in designing and implementing the condom availability plan. Member groups may be asked to sit on the design team or advisory committee, provide HIV and sexuality education in classrooms, train teachers and others who will be staffing the program, develop written or visual materials for students or accept referrals for other services. The coalition should continue to advocate for a program design that promotes condom use by sexually active teens and monitor the implementation of the program. ■

B. Identifying Stakeholders

The first step in creating community support for a condom availability program is to identify individuals and organizations who, whether they support or oppose condom availability, care about or will be affected by the program.

The most obvious of these stakeholders are students and parents, followed by principals who will implement the policy. Teens are clearly the group most affected, yet they are often left out of the decision-making process. (See "Working with Students" in Section II.C.)

There are other community groups and leaders who will feel strongly about the program. Identify conservative religious leaders and groups that have generated strong opposition to condom availability and sexuality education in other communities. Because much of the opposition to condom availability programs has been generated by the religious right, it is important to counter that opposition by identifying religious leaders and groups who are supportive.

A Stakeholders Analysis Worksheet (Attachment III.A) can help strategists identify those likely to oppose a program as well as those who will support it and those who may be neutral, but whose approval should be sought. The worksheet also suggests a system for ranking stakeholders for their importance to a successful initiative and for setting outreach priorities.

The list of stakeholders might include:

- students
- parents
- school faculty and staff (including health educators and nurses)
- teachers' unions
- public and community health staff
- social service agencies
- HIV/AIDS prevention organizations
- adolescent pregnancy prevention organizations
- youth-serving agencies
- religious leaders and organizations
- racial and ethnic associations
- civil rights groups
- gay and lesbian advocacy groups
- local chapters of national advocacy organizations
- health care providers
- civic groups
- elected officials.

C. Enlisting Experts

There will undoubtedly be questions about, and challenges to, the rationale behind or specific components of, any condom availability proposal. Coalition members (or advisors) should include experts in education, adolescent health and risk-taking behavior, religion and law who can respond publicly to misinformation, erroneous assumptions or the opposition's moral and religious claims. Experts can help coalition members evaluate challenges to the proposal and develop effective responses. When the school or health department is ready to develop a program plan, these experts can advise on the practical effects of policy and design choices for schools and teens.

The Resource List in Chapter 9 includes a list of organizations that have information, expertise or the ability to put schools and coalitions in touch with leading experts in the field.

II. DESIGNING A COMMUNITY EDUCATION CAMPAIGN

To create an education campaign, coalition leaders must make strategy decisions, assign tasks and responsibilities and establish a time frame. Key supporters who can participate in a broader education effort should be targeted first.

Use or adapt the Stakeholders Analysis Worksheet to set priorities and develop strategies. There is rarely a need to demonstrate unanimous support from any specific constituency, but demonstrating significant support is needed to carry on the campaign. With parents and students, for example, it is impossible to gain unanimous support for a condom availability program. It is important, therefore, to identify early the supportive and influential parents and parent groups. Extensive campaigns to inform all parents should wait until a plan is fairly well developed.

A. Outreach to Other Community Groups

Design strategies to assure that stakeholder groups:

- are aware of the problem
- understand the need for action
- support school condom availability as a part of the solution
- join the coalition
- coordinate and use organizational resources (newsletters, meetings, staff, funds, prestige, etc.) to educate and enlist other groups and individuals in support of condom availability and related goals.

Brainstorm strategies to reach each stakeholder. Do not count on a single approach when dealing with a variety of constituencies. Incorporate strategies for accessing each group according to the resources available and the characteristics of the targeted individuals or groups. Evaluate each strategy by:

- potential number of people reached
- how much it will cost
- amount of effort required
- how much time it will take
- ultimate impact on policymakers – particularly the school board.

Direct efforts toward stakeholders identified as likely supporters who were not included in early meetings, as well as to those whose position is neutral or unknown.

The coalition should also devise strategies for stakeholders who may oppose a condom availability plan. Some of these groups can become allies, if they are provided education and information to address their concerns.

Some groups, on the other hand, will never become supporters. The coalition should be aware of organized opposition in their own and other communities, and anticipate objections to the plan. (See Section V, "Responding to the Opposition.")

STRATEGIES USED IN EFFECTIVE EDUCATION CAMPAIGNS

- Face-to-face meetings by coalition members, including teens, with key opinion leaders (public officials, community leaders, media, clergy, etc.)±
- Presentations by coalition spokespersons, health department or school officials at board or membership meetings of civic, professional and advocacy groups+
- Materials targeted for a specific audience, including reports and fact sheets (these materials can also be made available for non-English-speaking audiences)
- Community forums or briefings for parent groups and neighborhood associations±
- Media outreach, including press conferences, guest editorials for the local newspaper, letters to the editor+
- Radio and TV news and talk show interviews
- Public service announcements, paid advertisements
- Petition drives among the general population or among specific groups such as students+
- Polls or surveys to gauge community opinion±
- Articles in local or organizational newsletters
- Fliers or posters
- Telephone trees among coalitions and advocacy groups to mobilize constituents for political action
- Speak-outs or rallies
- Direct action, such as handing out condoms or fliers with information about HIV infection and pregnancy rates.

±These strategies are described in greater depth later in this chapter.

+Samples are included in the appendices at the end of this chapter.

B. Outreach to Community Leaders

Coalition members, as well as supportive school and health administrators, play a role in securing the support of key opinion leaders in the community. The Stakeholders Analysis Worksheet can help determine whose endorsement could be critical for success.

Everyone identified as a potential supporter – including elected officials, city administrators in the health and human services departments, influential and civic-minded professionals, community organizers, leaders of parent groups, youth-serving agencies, health care providers and educators – should receive a personal visit from one or more of the major proponents of the school condom availability program. Face-to-face meetings allow for greater candor, lay the groundwork for future collaboration and reinforce the individual's importance to the process.

The most effective approach is a meeting of professional peers. Thus, regardless of their knowledge of the condom availability proposal, lower-level staff should not be sent alone to negotiate with political leaders or agency heads, but should accompany a well-briefed higher-level colleague or supporter.

TIPS FOR FACE-TO-FACE MEETINGS

Keep a record of who scheduled the appointment, who attended, what information was shared or action promised. Make appointments well enough in advance to prepare, confirm the meeting and invite other coalition members. If the community leader is unavailable, meet with the staff person responsible for health and education issues.

Choose participants well. No more than four coalition members should attend a meeting; give preference to those who have a professional or personal relationship with the person being visited. Party affiliation and other political considerations may also be a factor. If those with a direct connection are unable to attend, they should write or call prior to the meeting to lay positive groundwork for the meeting.

Include a teen and a parent in the delegation. The first-hand testimony of adolescents growing up in the age of AIDS is invaluable. It is especially convincing to include teenagers who are articulate and committed, given the common stereotypes of their apathy and unreliability.

The delegation should meet briefly ahead of time to identify key points to communicate and the role each member of the delegation will play in the meeting. Listening is equally important; designate someone to take notes.

Set a goal for the meeting. Depending on who is visited, the goal could be obtaining information, seeking endorsement of the campaign or getting a commitment to provide leadership. It is important to be specific about what is being asked and to make sure that everyone has the same understanding of what is committed. This helps avoid misunderstandings that could embarrass or damage the cause or impair the coalition's relationship with individuals whose goodwill is needed.

If the person visited supports the proposal, it is appropriate to ask for any of the following at this or subsequent meetings:

- signature on a petition of support
- the public use of his or her name
- signature on an endorsement form
- financial support
- a speech at a public forum
- agreement to lobby (other) policymakers
- agreement to write an article for a newsletter
- agreement to vote for a resolution
- agreement to take a leadership role such as chairing or participation in a specific committee, introducing a resolution endorsing the coalition at a potential member organization or at the school board, town council or legislature
- demonstrate support for the promotion of condom use by passing a resolution honoring February 14 - 21 as National Condom Week or by encouraging businesses to maintain condom vending machines on their premises. (See Attachments H.1 and H.2.)

(Continued)

TIPS (Continued)

To engage the stakeholder's participation in the process, solicit his or her advice on the next steps to take. Ask her or his perception of the political situation and his or her colleagues' views. Solicit data or anecdotes that will help the cause, as well as referrals to other potential supporters or experts.

Follow-up. If support is secured, include the person in the process by adding her or him to the mailing list and including him or her in public events, conversations and decisions as much as possible. Make sure he or she understands how much the coalition values his or her commitment.

If the person remains undecided, explore whether there is more information that might be helpful. Promise and deliver materials. Consider other strategies that might be persuasive.

If the individual remains opposed to condom availability, thank him or her for taking the time to discuss the issue and move on.

C. *Working with Students*

Schools and communities should be made aware that students are not passive or indifferent to this issue and that most students have strong and well-thought-out opinions.

Students themselves have provided some of the most convincing and stirring testimony on the need not just for condom availability but also for comprehensive responses to teen pregnancy and HIV/STD infection.

In some high schools where condom availability has been approved, students were solely responsible for bringing this controversial issue to the community's attention and persisting in the face of tough opposition. Elsewhere, students have worked with adults on every aspect in the evolution of condom availability, including education, advocacy, community organizing and the design and implementation of the actual program.

Encourage students to play a central role and to take responsibility for the program's ultimate outcome. Students can get involved in powerful and creative ways – vastly enriching the effectiveness of the coalition, as well as enabling them to feel ownership of a program once it is in place.

Possible Student Actions. The following are a sample of the many actions students can take to promote condom availability, as well as to help their peers understand and cope with issues related to sexuality and the consequences of sexual activity:

- Conduct a petition drive among students, faculty and/or parents who favor condom availability.
- Provide personal testimony and an adolescent viewpoint at public meetings and community hearings.
- Submit guest editorials and articles to the school and/or community newspapers.
- Meet with principals, teachers and/or nurses to discuss possible ways the school can respond more effectively to teen pregnancy, HIV and other STDs within the student population.

- Survey students about their knowledge and attitudes regarding HIV, access to contraceptives, including condoms, and the kind of program they would be most comfortable using should condom availability be approved.
- Form a student group to discuss regularly issues related to sexuality, pregnancy and HIV/STD prevention.
- Devise new educational approaches, such as student-led workshops or counseling sessions, to help students avoid risky behaviors.
- Organize school assemblies dedicated to teen sexuality issues. Include a discussion on condom availability.
- Organize a student speakers bureau to serve the student population and the general community.
- Participate in meetings with key community leaders.
- Network with students from other school districts and form a coalition of students interested in improving the community's response to the reproductive health needs of youth.
- With professional supervision, participate in or conduct focus group and needs assessment research. (See Attachment III.G.3, for the "Condom Hunt" exercise.)
- Participate in condom availability program training.
- Help design the program.
- Help implement the program.

GETTING INVOLVED: TIPS FOR STUDENTS

Don't Be Afraid to Take Initiative. You, much more than your adult counterparts, can influence the way your peers think about sexual risk-taking. You also can strongly influence the way your school chooses to discuss sexuality and sexual risk-taking. Never underestimate your abilities or your ideas.

Remember, Condom Availability is a Controversial Issue. It may be politically difficult for your superintendent, principal or faculty to fully support your efforts. Do not compromise your views, but do try to work cooperatively with school authorities. Also, it is better to do everything openly and to inform your principal and/or appropriate faculty of any event or project you might be planning within the school grounds.

Know Your Rights. Before you act, take time to investigate your rights on school property. Most schools have a book of rules and regulations. If some seem questionable to you, contact your department of education for clarification as well as the state and local chapters of the American Civil Liberties Union for assistance in understanding your First Amendment rights. It is possible that you will need to hold some actions off school grounds.

Do Your Research and Know the Facts. Take time to arm yourself with statistics, especially – if they are available – local ones, on the rates of teen pregnancy and STD and HIV infection. Make use of the resources at your fingertips, including the National AIDS Hotline (1-800-342-AIDS), your local health department and community AIDS action groups.

Find a Supportive Adult. Teens are capable of organizing an entire campaign; a supportive counselor, teacher or parent, however, may be able to lend objectivity, help you stay on track, assess your options and anticipate problem areas. ▣

INVOLVING YOUTH: TIPS FOR COALITIONS

Many community groups already involve and work closely with youth on a variety of issues. The following are tips on how to start and improve involvement of young people in the activities of coalitions:

Recruit Within the Community. Start with the school community itself. School districts vary in the extent to which they involve students in their program and policy decisions. Some districts have teen members on the board of education or involve youth through established teen advisory councils. Contact the department of education for information about how the system works and the names of youth leaders.

Next, contact peer education and youth leadership programs in the community, especially those focusing on teen sexuality issues. Agencies such as Girls, Inc., Planned Parenthood, the YWCA and YMCA and Boys and Girls Clubs of America are good places to start. Local HIV prevention/outreach organizations might be helpful. Consider placing public announcements, especially in places teens gather.

Be Open and Non-Judgmental. Be genuinely open to young people's insights and suggestions. Let them know immediately that their involvement is crucial. Students know their peer community better than anyone and this is a good opportunity to gain a deeper understanding of teenagers' experiences and feelings. To this end, be aware of how adult members respond to the ideas put forth by youth. Subtle negative reactions can squelch young people's energy and commitment to the project. Furthermore, adults are not always inclined to take teens' ideas seriously and may dismiss good ideas or suggestions based on preconceived notions toward youth.

Enable Youth to Participate in Meaningful Ways. Ideally, young people should participate in all decision-making. In addition, students may want to identify their own project to carry through to completion. Help the students design and set up their project.

Be Honest about Expectations. To keep the interest and high energy level of teens, it is important to maintain a sense of humor and a perspective about the mission: enabling young people to lead more healthy, viable futures. Consistent with that philosophy, give students responsible tasks, although they can be asked to help out with the administrative and less glamorous jobs, just like everyone else.

Integrate Youth into the Coalition. Appoint one person to coordinate youth and keep them updated and informed about the overall plan. *All* youth members should be contacted about any changes in plans. Think about whether or not meetings are held at an accessible location for student members.

Be Responsible About How You Involve Youth. Condom availability is a controversial issue, apt to receive publicity and stir a few outraged voices in the community. If students' ideas are to be supported and respected, students must lay out their options, research their rights and strategize wisely. They need to be prepared for the possibility of hostile responses from the community. ▣

III. WORKING WITH THE PRESS

Issues concerning adolescents, HIV/AIDS and condom availability attract press attention. Media coverage is important because it carries the message to many more people than could be reached independently. Carefully planned media strategies help reach those who can be mobilized and help persuade those who are undecided or opposed to condom availability. The media also can diffuse criticism by providing the forum to explain the condom availability program and demonstrate thoughtfulness, sensitivity and candor.

A. Planning Your Media Campaign

All successful media plans usually follow a basic four-step process:

1. Define the role of the media in outreach efforts. Be aware of media coverage of related issues (sexuality, HIV, adolescence) and provide copies of past coverage in briefing packets. Keep records on local and national press (both those who have been contacted and potential contacts). Keep accurate mailing, telephone and fax lists.
2. Determine what kinds of press activities to hold and which materials to have on hand as background or current information. Consider sending out press releases, creating a press packet, holding a press conference or using a variety of other techniques.
3. Be aware of the leading spokespeople for the opposition and the media strategies they employ; be prepared to respond.
4. Evaluate your press campaign. Keep track of stories, determining how the story was presented, who was quoted and what kind of follow-up may be necessary.

B. The Spokesperson and Interviews

Effective media strategies highlight the broad cross-section of community members who support the coalition and encourage them to play an active and visible role.

Calls from the press should be routed to one person designated as the spokesperson, to establish a regular contact for the reporter and to allow for follow-up. This person should be articulate and well-versed on HIV/AIDS, pregnancy prevention education and condom availability issues. In some situations, more than one spokesperson might be designated. In any case, others in the coalition should be briefed on these issues, in the event of a separate interview.

When speaking with the media, it is crucial to be clear and direct, to know what points to make and how to make them succinctly. It helps to anticipate difficult questions and practice answering them in a role-play situation before interviews.

If the spokesperson does not know the answer to a question, it is important for him or her to say so. If the question is outside of his or her area, the spokesperson should say so, and explain why. The reporter has a right to ask anything and expect that the spokesperson will answer to the best of his or her knowledge. The respondent has the right not to be drawn into issues that she or he feels are inappropriate for comment. If, however, the spokesperson does comment in these areas, his or her remarks are fair game and may be made public. Saying something is "off the record" is no guarantee that it will not appear and no guarantee that a name will not be attributed to it.

If the respondent is not a spokesperson for the organization, but is providing background information, make the relationship to the coalition clear and let the reporter know who to talk to for attribution. If there is a subject on which the spokesperson does not want to be quoted, the safest rule is to not talk about it. Do not be drawn into criticism of colleagues or other organizations. Reserve criticism for real adversaries or for motivating public officials.

The Respondent Has Rights in the Interview Situation:

- to answer a question in his or her own way and words
- to refer to research materials
- to be quoted fairly and in context
- to have her or his schedule respected
- to not talk to a reporter or to refuse an interview, within reason.

C. The Press Information Packet

One of the most important items for a press campaign is the press information packet. It contains basic background material that covers the program's issues and describes the coalition. It can be used to insert press releases and advisories for conferences or briefings. A standard packet includes:

- a description of the organizations involved in the program
- background on adolescents and AIDS, adolescents and STDs, adolescent sexual activity and pregnancy rates
- condom availability programs already in place
- brochures developed by the coalition
- an organizational newsletter
- news clippings of stories and editorials on these or related issues
- materials for a press conference, such as news advisories, news releases, statements from the group leader or copies of their speeches or testimony.

D. Building Relationships with the Media

When the Press Calls. Calls should be directed to a spokesperson who will either respond to the inquiry or refer the reporter to an appropriate person for additional information or an interview.

Try to respond to all media calls. Don't avoid press calls. Leaving a "no comment" impression may arouse suspicion. Responding quickly will increase the chances of being quoted and cited in the final story.

Be aware of "sensationalist" journalists, those who have stated their opposition to condom availability or those who work for newspapers with an editorial position against condom availability. Be especially cautious when working with these journalists.

When Contacting the Media. To be most effective in dealing with the press, know who to call when there is something to say.

- Newspapers: Identify the editor or call the assignment desk.
- Television: Start with the assignment desk. TV public service directors and editorial directors also are good contacts, particularly for public affairs programming. Some correspondents also take part in deciding which stories are covered.
- Radio: Identify news directors and talk show producers to whom the story and interview ideas may be pitched.

WHEN IS A STORY "NEWS"?

- It concerns an emerging issue.
- It affects a large number of people.
- It involves action of some kind.
- It involves "important people."
- It generates "human interest."
- It contains an element of conflict or controversy.

E. Methods for Approaching the Media

News Releases. A news release is a one-to-two page description of an event, program or activity. Distribute a news release by mail, fax or messenger or hand it out at conferences and press briefings. It can stand alone or be enclosed with additional materials and resources. News releases should be distributed with sufficient lead time and include the following:

- one or two quotes from spokespeople
- date on which the information can be released
- facts: who, what, where, when, why and how
- contact name and telephone number.

(See Attachment III.E.4 for a sample Press Release.)

News Advisories. A news advisory is sent to announce an event or specific news; it is a simple one-page document that invites coverage of an event. Include a description of what is happening, when, why, where and who is participating.

News Briefings and Press Conferences. Briefings should be reserved for announcements that cannot be communicated well in a press release. When possible, schedule the briefing or conference in a location convenient to the reporters (a city press club or downtown location). A briefing on the overall issues of the program might be appropriate at the beginning or after a great deal of change.

Public Service Announcements (PSAs). For radio, write a 15-to-20 second statement or announcement and submit it by fax or mail. Television PSAs will need to be produced, but the only cost is for production, not distribution. PSAs are recommended for community calendars and announcements.

Local Cable Access Programming. Cable access channels offer access to equipment, air time and consulting and are an excellent venue for local issues. PSAs, panel discussions or other programming are possible; contact the local cable company for more information. In many areas, cable channels will film public forums or debates.

Buying Space or Time. Buy space for a prepared advertisement to appear in local newspapers or magazines. Newspapers and magazines have rate cards that explain ad sizes and prices. Buying time for radio advertisements is relatively inexpensive. Check with local stations for rates, listenership and technical requirements for submitting advertisements. Some stations allow radio personalities to read ad copy on the air; others use only advertisements that are produced on tape. (See Attachment III.K.)

Letters to the Editor. Newspapers frequently print letters to the editor that address an issue which has been in the news recently. Letters should be clear, brief and timely.

Guest Editorials. Guest editorials, or "op-eds," are brief essays on topics in the news or of public concern. Op-eds should be approximately 500-600 words in length and make one major point. The organization's name appears in the byline that identifies the author. (See Attachment III.I)

Letters to Media Professionals. Maintain press contacts through letters to reporters, editors, talk show producers and editorial boards. Use letters to suggest interviews or topics for press consideration, to acknowledge good coverage of an issue or to praise a reporter or editor.

F. Evaluating Press Relations

The crucial factor in understanding and evaluating press experience is in setting realistic expectations. A news story, at best, presents the proponents' side of the story fairly and evenly. It also presents other viewpoints. It should incorporate at least one of the major points raised in the interview. It will quote spokespeople accurately. But most important, a press piece should not only educate the community about challenges the program confronts but also lay the foundation for greater awareness and support.

IV. SPONSORING PUBLIC MEETINGS

Give careful consideration as to whether to sponsor public meetings, to encourage the school board or town council to hold public hearings or to be drawn into formal debates on the issue. Make decisions as to which activity should occur and at what point in the process.

For instance, if a task force has been formed to look into the problem of adolescent HIV/STD infection or pregnancy, a public meeting to discuss the findings and recommendations might be appropriate. If the task force was charged with developing a plan to address the problem, a briefing might be in order. If the task force has completed their briefing, the school board may call for a public hearing on the plan which has been developed. A community organization may decide to schedule a debate between opponents and proponents of the plan. Each of these public events requires considerable preparation.

Prepare for a public information meeting by building the strongest case, anticipating and responding to probable objections and identifying the most articulate and knowledgeable speakers. Make an assessment about the appropriate number of coalition members to be in the audience at these events and then make sure they attend.

A public information meeting may be appropriate to notify the public about the need for a condom availability program, answer any questions or concerns, get support for the concept and address any hostile charges. The purpose of this type of meeting is **not** to provide the opposition a forum for a debate; it is to provide information to interested members of the public. Listen to the concerns and objections of those who oppose the plan, however, and make a genuine effort to take them into account as planning proceeds.

TIPS FOR A PUBLIC INFORMATION MEETING

1. Select a Moderator

Obviously, in this type of setting, meeting management is important. Recruit a strong, objective moderator who is not an active member of the coalition. The moderator's role is to keep to the agenda and the ground rules, to keep discussion moving and to keep order.

2. Draft an Agenda

Develop and circulate an agenda in advance of the meeting. Ideally, it will allow some period of time for the chair of the coalition or task force to present their findings and then allow time for questions from the floor. Post the agenda in the meeting room or have copies available for audience members.

3. Set Ground Rules

Establish ground rules in advance and ensure that the moderator will strictly enforce them. Consider not only matters of common courtesy and the length of time any individual may dominate the discussion, but also whether participants must be parents, members of the community, etc. Should speakers be required to register before the meeting begins? Should proponents and opponents alternate turns at the microphone? Should individuals be required to represent themselves, or is this a forum in which organized special interest groups are allowed to present their objections to or support for the plan? There is no single correct answer to these questions, but the coalition should make decisions that can be announced in advance.

4. Prepare Handouts

Prepare material to distribute. Consider fact sheets that summarize the results of the needs assessment, articles from local papers or about programs in other areas and lists of supporters (both local individuals and groups as well as national groups). Give thought to translating some or all of the material for non-English speaking participants. ■

V. RESPONDING TO THE OPPOSITION

Just as important as identifying friends, allies and advocates on the issues, it is vitally important to know who opposes condom availability, why they oppose it and what strategies they use. Do not assume that everyone who opposes condom availability does so for identical reasons.

Some individuals may oppose the program because they lack full information about the plan, what it seeks to accomplish and how it will be implemented. Objections often are to specific aspects of the proposed plan. More information may be all that is needed. Some may resist the plan because they feel left out of the process. Evidence that planners made extensive efforts to involve the community (especially parents) in the earliest discussions of the program may mollify these individuals.

Some parents may see condom availability in schools as a sign that their children are growing up and away from them and becoming adults. Others may see it as one more effort to divert the school's attention from providing the best

possible education for their children. Still others may think it is simply unnecessary. This group most often expresses its reservations in such terms as: "school isn't the place for this sort of program."

These concerns need to be heard. By listening rather than trying to overpower, the coalition and school leaders open genuine communication. The strength of proponents' arguments may then be persuasive.

Some organized opposition groups, on the other hand, are not open to persuasion. Organized groups opposing these programs usually do so from a religious and/or political perspective that believes that only marital sex is acceptable. Adamantly opposed to sexuality education, contraception, abortion and homosexuality, these opponents have extensive networks and experience in political and community organizing.

On occasion, these groups have organized bus loads of their followers from neighboring cities to speak against condom availability at public hearings. Other strategies include misrepresenting data and making moral claims and accusations. While these organized groups represent only a small minority in any community, their arguments are often shrill and confusing.

A. Suggested Responses to Arguments Against Condom Availability Programs

What follows are some of the typical arguments used by the opposition and helpful hints on how to respond. This is by no means a comprehensive list, but focuses on major themes being echoed around the country.

One group of arguments is about the messages that condom availability programs give. Opponents will say:

- Abstinence is the only truly effective means to prevent pregnancy and STDs; there is no such thing as "safe sex."
- Condom "distribution" encourages teens to have sex.
- Condom failure rates are very high. Telling teens they should use condoms gives them a false sense of protection.

It is important for all proponents to stress that they know abstinence is the only guarantee against unwanted pregnancy and infection with HIV or other STDs. The comprehensive plan should include messages about abstinence. Teens who choose to be abstinent or delay sexual activity, despite all of the biological, emotional and environmental pressures to "do it," need to be supported.

But abstinence-based messages must be only *part* of the program, not the only message teens hear. Abstinence-only messages are shown to be ineffective with teens who have already started sexual intercourse. The Centers for Disease Control and Prevention (CDC) report that 70 percent of students have had sexual intercourse by their senior year of high school.

Condom availability programs do not cause teens to be sexually active. Nor do condom availability programs indiscriminately hand out condoms to teens who do not request them; condoms are made *available* to those who need them, not *distributed* to all students. Studies have found that school-based health centers that provide contraception on-site neither hasten the initiation of sexual activity nor result in greater frequency of intercourse among students. Such programs only offer protection to teens already engaging in sexual intercourse.

Condom availability programs acknowledge that for teens who are sexually active, consistent and correct condom use will significantly reduce the risk of pregnancy and STD/HIV transmission. Teens are taught that proper use of latex condoms, while not 100 percent effective, will decrease risk. Comprehensive condom availability programs teach teens decision-making and negotiating skills as well as skills to resist peer pressure.

It is important that teens receive accurate information about the choices available to them, from the efficacy of abstinence to the probability of STD or HIV infection or of causing a pregnancy if no method is used. The "Condom Efficacy and Use Among Adolescents" Fact Sheet (See Attachment I.A) provides information on standards for condom manufacture and additional data on the effectiveness of condoms in preventing pregnancy and the spread of disease.

A second group of arguments maintains we do not need to worry about AIDS. Opponents say such things as:

- The number of adolescents with AIDS is small – the problem has been blown out of proportion.
- AIDS is not an adolescent disease, it is an adult disease.
- There is no real epidemic, and our community is certainly not at risk. We do not have anyone with AIDS in this community.

While it is true that the number of adolescents with AIDS comprises less than 1 percent of all AIDS cases, more than 20 percent of people with AIDS are in their 20s. Of people who tested positive for HIV in 1991 and whose age is known, more than a third are under 30.[1] Given the average latency period of 10 to 12 years between infection and onset of symptoms, most of these young adults were probably infected with HIV in their teenage years.

Young people growing up in this decade must learn skills and habits that will protect them not only now but in adult life. Condom availability programs recognize the fact that HIV does not discriminate. Students need to know that it is not possible to tell by appearance whether someone is HIV positive. People with HIV can lead normal, productive and fruitful lives for many years. Their healthy appearance, however, adds to community denial.

Communities are not completely isolated from the rest of the country, as adults and young people move more frequently and travel extensively. It only takes one infected individual engaging in unprotected intercourse to begin a chain of infection.

Chances are there *are* people in almost every community who are either HIV-positive or who have AIDS. Many people do not know their HIV status. Others know that they are HIV-infected but do not share that information with sexual partners. In some states, aggregate HIV prevalence data are available to counter this argument. Check with state or local health departments for statistics.

Another group of arguments is that parents should be their children's sole sexuality educators or that they do not approve of condom availability programs. Opponents says such things as:

- It is solely the parents' responsibility to inform their children about sexuality issues, not the schools'.
- Parents do not approve of these programs and will not support them.

Parents *are* the first and primary sexuality educators of their children. Optimally, parents provide, both verbally and nonverbally – through discussion and acting as role models – the values and guidelines for all aspects of what they deem to be acceptable behavior. Yet parents often express the need for help in discussing sexuality and AIDS prevention with their children. Further, many teens do not have stable homes where they can seek information and guidance on these subjects. HIV prevention and sexuality education programs aim to compliment and augment parents' responsibility, not to replace or undermine it.

The majority of parents understand the risk adolescents face and support efforts to protect them. According to a 1988 poll by Louis Harris and Associates, 73 percent of adults favor making contraception available in schools. A 1991 Roper poll found that 64 percent of adults say condoms should be available in high schools. In Portland, Oregon, 72 percent of parents surveyed supported school-based health centers making contraceptives available to prevent the spread of STDs. In 1992, a National Scholastic Survey found that 81 percent of high school seniors felt condoms should be available in schools.

A final opposition argument is that the school is not the appropriate place for this type of program. Arguments include:

- Teens who want condoms can get them at any drug store; there is no need for them at the school, too.

It is true that teens have a legal right to purchase condoms at any drugstore or convenience store, but that does not guarantee unimpeded access. A 1988 survey of drug stores by teens in the Washington, D.C. area found teens had to overcome significant barriers in order to purchase condoms, including disapproving clerks and difficulty locating condoms on the shelves.

The problems may be complicated further for low income and rural teens, who find the cost of condoms an obstacle, who may not have transportation or who may fear encounters with friends or neighbors behind the counter or shopping in the store. While some family planning clinics have attempted to be sensitive to teens' needs by scheduling special hours, having specially trained workers or establishing outreach sites, this is not always the case.

School is where a majority of teens spend their non-home hours. A well-designed school condom availability program does more than expand access to condoms; it teaches sexual decision-making and negotiation skills and signals to sexually active teens that the community cares about their future.

Notes

[1]The Centers for Disease Control, *Morbidity and Mortality Weekly* 41:34 (August 28, 1992).

CHAPTER THREE ATTACHMENTS

A. Stakeholders Analysis Worksheet

B. Statement in Support of Condom Availability Programs in Public Schools

C. Sample Organizational Statement, American School Health Association Approved October 1992

D. Sample Testimony: New York City Commissioner of Health

E. Sample Coalition Activities: Washington D.C. Condom Availability Coalition

   1. Organizational Endorsement Form
   2. Petition
   3. Sign-on letter
   4. Press Release
   5. Colleague Letter to City Council Members

F. Sample Letter: Chicago Community-Based Organizations

G. Involving Youth

   1. Sample Testimony
   2. Student Petitions
   3. Sample Activity

H. Sample Legislation Supporting Condom Access and Use

   1. Boston City Council
   2. Resolution Declaring National Condom Awareness Week

I. Guest Editorials and Columns

   1. "Condoms in the Schools: The Right Lesson," Paul Epstein, *The New York Times*, January 20, 1991
   2. "To Save Our Children's Lives," Linda W. Cropp, *The Washington Post*, May 13, 1992

J. Sample Advertisement, Emergency Task Force on HIV/AIDS, New York City

K. Sample Radio Advertisements, Families Concerned About AIDS, New York City

L. The Center for Population Options Responds to Negative Articles on School-Based Health Centers

STAKEHOLDER'S ANALYSIS WORKSHEET

YOUR GOAL:

RANK	STAKEHOLDERS	A	B	C	D	E	MAJOR INFLUENCES

RANK	POLICYMAKERS	A	B	C	D	E	MAJOR INFLUENCES

INSTRUCTIONS FOR USING THIS WORKSHEET:

STEP 1: STATE YOUR GOAL.

STEP 2: LIST STAKEHOLDERS. Identify all persons or groups involved in achieving your goal. Who cares? Who has a stake in seeing the defeat or success of this measure?

STEP 3: EVALUATE STAKEHOLDERS' "READINESS CAPACITY". Indicate the level of involvement for each of your stakeholders, and their readiness to help achieve or block your goal. Put an "O" in the column that best represents where each stakeholder is at the present time, and an "X" in the column that best represents the position that you need that stakeholder to take.

KEY: A = ACTIVELY OPPOSED
B = NOT AWARE, OR NEGATIVELY INCLINED
C = WILL LET IT HAPPEN
D = WILL HELP IT HAPPEN
E = WILL TRY TO MAKE IT HAPPEN

STEP 4: RANK STAKEHOLDERS according to the importance of changing their "readiness capacity". By setting priorities, you focus your effort, conserve energy and increase effectiveness.

How necessary is each stakeholder to your success? How much effort will be needed to enlist them in your cause? Remember, some individuals exercise leadership and control the process. Others wield influence, and bring additional support with theirs. Some people have a negative influence, and you want them to be less involved.

STEP 5: ANALYZE STAKEHOLDERS. What are their goals and concerns? How do they currently perceive you and your goals? Are there ways to sharpen the focus of the stakeholders on your goals, and increase the alignment between their interests and yours? Who influences them? How are they perceived in the community? Who else should be on the list?

STEP 6: DEVELOP WINNING STRATEGIES. Consider how most effectively to: build coalitions; enlist advocates and spokespersons; mobilize constitutnecies; utilize the media and publicity; neutralize opposition.

STEP 7: REPEAT STEPS 1 - 6 FOR POLICYMAKERS.

Statement in Support of Condom Availability Programs in Public Schools

The National Coalition to Support Sexuality Education (NCSSE) is a group of more than 50 national non-profit organizations, many of which are noted role models and initiators in promoting the health, education, and social concerns for our nation's youth. The Coalition is committed to the mission of assuring that comprehensive sexuality education is provided for all children and youth in the United States by the year 2000. Among that leadership coalition, 19 organizations have endorsed the following statement in support of condom availability programs.

THE NATIONAL COALITION TO SUPPORT SEXUALITY EDUCATION

Statement in Support of Condom Availability Programs In Public Schools

More than half of American teenagers have had sexual intercourse and face significant sexual health risks. Each year, over one million teenagers become pregnant, one in seven teenagers contract a STD, and one in five hundred students on college campuses are infected with HIV.

Schools have an essential role to play in providing young people with sexuality education. Teenagers need accurate information and education about sexuality, opportunities to explore their values in supportive environments, and encouragement for responsible decision making. Education, about abstinence, alternatives to intercourse, sexual limit setting, and resisting peer pressure, should support adolescents in delaying sexual intercourse until they are ready for mature sexual relationships. Young people who choose to be involved in sexual relationships need ready access to prescription and nonprescription contraceptive and prophylactic methods.

Condom availability programs have been proposed in many communities in order to help protect the health of sexually active adolescents. The following members of the National Coalition To Support Sexuality Education support and encourage the development of condom availability programs in high schools. These programs must be coordinated with sexuality and HIV/AIDS education programs in order to provide sexually experienced young people with the information and motivation they need.

Parental and community involvement in the design of these programs is encouraged. It is generally desirable for parents to be involved with their children's sexual and contraceptive decisions. However, the right of every individual to confidentiality and privacy, regardless of age or gender, in receiving such information, counseling, and services, should be paramount.

American Association for Counseling and Development
American Association of Sex Educators, Counselors and Therapists
American Home Economics Association
American Social Health Association
Association of Reproductive Health Professionals
Center for Population Options
Child Welfare League of America
Coalition on Sexuality and Disability, Inc.
Hetrick-Martin Institute for Lesbian and Gay Youth
National Education Association Health Information Network
National Family Planning and Reproductive Health Association, Inc.
National Gay and Lesbian Task Force
National Lesbian and Gay Health Foundation
National Network of Runaway and Youth Services
Planned Parenthood Federation of America
Sex Information and Education Council of the U.S.
Society for Behavioral Pediatrics
U.S. Conference of Local Health Officers
University of Pennsylvania

For more information about NCSSE, contact: SIECUS, 130 West 42nd Street, Suite 2500, New York, NY 10036, 212/819-9770, fax 212/819-9776.

American School Health Association Position Statement Approved October 1992

LATEX CONDOM AVAILABILITY PROGRAMS IN SCHOOLS

The American School Health Association (ASHA) is committed to saving the lives of students who are at risk.

Although refraining from sexual intercourse is the best method of preventing pregnancy and sexually transmitted diseases, including HIV, recent data show that by age 20 seventy-five percent of adolescents engage in coital activity,[1,2] many with multiple partners.[2] Each year, one in six sexually active teenagers contract an STD[4] and over one million teenagers become pregnant.[5] Spread of the HIV among the adolescent population has been documented through seroprevalence studies.[6]

Schools should play an integral role in the public health effort against HIV/AIDS through comprehensive health education and services, and school-community coalitions. While the emphasis in all these programs should be abstinence, comprehensive school health programs should also meet the needs of those youth who choose to be sexually active. The goals of such instruction are (1) to provide accurate information, (2) to support students who do not engage in high risk behavior, (3) to encourage those engaging in high risk behavior to stop, and (4) to teach those who choose to engage in high risk behavior how to reduce their risk of contracting the HIV,[7] STDs, and to prevent pregnancy.

Latex condom use has been shown to be effective in preventing the spread of STDs and AIDS[8] even though they sometimes fail. Whether or not latex condoms are made available to adolescents in schools, instruction about effective use of latex condoms must be provided. Thus, the American School Health Association supports latex condom availability programs when they are offered in concert with a comprehensive school health program, including HIV/AIDS and sexuality education. Since latex condoms are legally accessible to adolescents in the United States, availability through educational institutions does not entail the introduction of an otherwise unobtainable product. A latex condom availability program should be designed with parental and community involvement and have established implementation and evaluation guidelines. While such programs recognize the role of parents in their children's sexual decisions, the right of each student to confidentiality in receiving these services should be foremost.

References

1. Centers for Disease Control. Premarital Sexual Experience Among Adolescent Women, United States, 1970-1988. Morbidity and Mortality Weekly Report. 39:929 (January 4, 1991).

2. Sonestein FL, Plek JH, Ku LC. Sexual Activity, Condom Use and AIDS Awareness Among Adolescent Males. Family Planning Perspectives. 21(4):152-158 (July/August 1989).

3. Centers for Disease Control. Selected Behaviors that Increase Risk for HIV Infection Among High School Students, United

States, 1990. Morbidity and Mortality Weekly Report. 41:231 (April 10, 1992).

4. Annual Report, Division of STD/HIV Prevention. Centers for Disease Control, Atlanta, Ga, 1989.

5. Henshaw SK, Van Vort J. Research Note: Teenage Abortion, Birth, and Pregnancy Statistics: An Update. Family Planning Perspectives. March/April 1989.

6. DiClemente RJ. Epidemiology of AIDS, HIV Prevalence and HIV Incidence Among Adolescents. Journal of School Health. 62(7):325-330. (September 1992).

7. CDC AIDS Education Guidelines. Atlanta, Ga: Centers for Disease Control; 1988.

8. Hatcher RA, Stewart F, Trussell J, Kowal D, Guest F, Stewart GK, Cates W. Contraceptive Technology, 15th revised edition. Irvington Publishers, Inc., New York, 1990-1992.

Sample Testimony: New York City Commissioner of Health

HIV AIDS INITIATIVE:

STRATEGIES FOR PROTECTING NEW YORK CITY'S ADOLESCENTS

PRESENTATION TO THE BOARD OF EDUCATION

BY

WOODROW A. MYERS, M.D., M.B.A.

COMMISSIONER OF HEALTH

CITY OF NEW YORK

JANUARY 16, 1991

I am very pleased to be here today to speak in support of Chancellor Fernandez's plan for an expanded HIV/AIDS education program. This is a critical time for this much needed initiative. Few things can be as important--or more fundamental--than the health and well-being of our youth.

This is a very somber day. While the specter of an international war hovers ominously over the country, we must also recognize--and face squarely--the ravages of a very different war that is being played out daily in our own backyard.

We are now ten years into the AIDS epidemic. The mounting devastation of this terrible disease can be seen all around us, and it is evident that the adolescent population sits directly in its path. Already, New York City has a greater number of teenagers with AIDS than any other city in the nation. More than 20% of the adolescent AIDS cases reported in the United States have been reported in New York City, while only 3% of this age group actually live here[1]. AIDS is now the leading cause of death for women ages 25-39, a large proportion of whom were clearly infected when they were in their teens[2].

It is critical to bear in mind that the urgency of the problem cannot be measured simply by the numbers of AIDS cases. At the

[1]Centers for Disease Control and New York City Department of Health

[2]New York City Department of Health

present time, the absolute number of AIDS cases among our city's teenagers is, in fact, relatively small. However, full-blown AIDS cases represent just the tip of the iceberg. Because the interval between infection and development of symptomatic disease can be as long as 8-10 years or more, for every case of AIDS diagnosed there are many, many more who are infected but not yet sick. And sadly, there are even larger numbers of teenagers in this city who, while not infected today, are at substantial and ongoing risk.

During my previous testimony before the Board, I discussed these issues in more detail, but let me reiterate a few key points to underscore the urgency of moving forward with the Chancellor's proposal:

- Whether we like it or not, close to 80% of our teenagers are sexually active by age 20[3]. Each and every one of those teenagers is at risk of HIV infection unless they have the knowledge and the resources to take appropriate precautions.

- One small measure of the level of unprotected intercourse is the fact that almost 35,000 pregnancies occurred to girls under age 19 in New York City in 1989[4].

- In addition, there were over 11,000 adolescents under the age of 19 diagnosed with sexually transmitted diseases (STD's)[5]. That number probably underestimates the actual numbers of youths with STD's, but it is clearly an ominous sign of high risk behaviors with serious implications for health. Sexually active teenagers have the highest rates of STD's of any group, presumably due to lack of knowledge about this health concern and lack of skill in using preventive measures.

The issue of adolescent sexuality and consequent risk of HIV infection is not a theoretical concern or an issue that we have the luxury to sit around and debate in the hopes of arriving at a perfect, non-controversial solution. We must take action now... for AIDS is a preventable disease. From a public health perspective, we know how the virus that causes this fatal disease is spread and we know what steps can be taken to limit its spread. Teenagers must be educated about the hazards of HIV, the specific behaviors that put one at risk for HIV transmission and how spread of the virus can be prevented, including accurate information about condoms and access to their use.

We have to come to terms with a very sensitive and complex issue. Medically, we know that condoms can protect against serious health risks, including HIV, other STD's and unwanted pregnancy. While there is no 100% guarantee that condoms will always prevent HIV infection, they do provide the best protection available for those who chose to engage in sexual intercourse. In fact, a recent research study attempting to model HIV risk difference between condom users and nonusers among U.S. heterosexual women estimated that given current HIV-incidence levels in U.S. women, condom-use failure rates in terms of HIV infection would be less than 1% per

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[3]F.L. Sonenstein, H.J. Pleck and L.C. Ku, "Sexual Activity, Condom Use and AIDS Knowledge among Adolescent Males," Family Planning Perspectives, Jan/Feb, 1988 and data from the National Survey of Family Growth, National Center for Health Statistics.

[4]New York City Department of Health

[5]New York City Department of Health

year, substantially lower than the 10% estimated condom-user failure rate for pregnancy The report also projected that up to 45% of all new HIV cases might be prevented if condoms of approved quality were in consistent and widespread use[6].

Abstinence is the best way for an individual to oneself from HIV infection. Nonetheless, we cannot let wishful thinking cloud the evidence that without more realistic and aggressive intervention strategies, there will be continuing and increasing HIV transmission among our youth.

The concern has frequently been expressed that sex education and/or access to condoms will actually result in increased sexual activity and increased harmful consequences. This is an understandable concern, but good scientific studies do not substantiate it; nor does the experience of our Western European counterparts where sex education, and condoms are readily availabile at no cost to adolescents. Such Western European countries do not have either higher rates of sexual activity or an earlier age of sexual initiation. What they do have, however, are lower rates of teen-age pregnancy, lower rates of abortion, and lower rates of sexually transmitted diseases, including HIV infection and AIDS.

In fact, a distinguished panel established by the National Academy of Science--an organization in which I have a great deal of confidence--reviewed the available data and reported that "there is no available evidence to indicate that availability and access to contraceptive services influence adolescents decisions to become sexually active"[7].

These facts and the alarming rate of sexually transmitted diseases and teenage pregnancy caused our neighboring city of Baltimore to initiate a program which makes condoms and foam available without parental consent in nine middle and high schools. Since September of this past year, school-based clinic staff make condoms and foam available to any sexually active student, whether or not they are enrolled in the clinic. Students sign a confidential consent form. Plans call for condom and foam availability in Baltimore schools without clinics in the near future.

As the father of an adolescent girl, I know first-hand the complexity (and perplexity) of the concerns surrounding adolescent sexuality. Certainly, we should continue to support and encourage teenagers to delay sexual activity until they are emotionally mature enough to enter an intimate, lasting relationship. Nonetheless, our hopes must confront reality. As Commissioner of Health, I must advocate for the public health needs of our city's youth, both those that are sexually active and those that are sexually abstinent.

Over the past few months, The Department of Health has worked closely with the Chancellor's office in an attempt to develop an expanded HIV/AIDS education and prevention strategy for

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[6]J.A. Perlman, J. Kelaghan, P.H. Wolf, W. Baldwin, A. Coulson, and A. Novello, "HIV Risk Difference Between Condom Users and Nonusers Among U.S. Heterosexual Women," Journal of Acquired Immunodeficiency Syndromes, Vol. 3, No. 2, 1990.

[7]National Academy of Sciences, Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing, National Academy Press, 1987.

implementation in our city's high schools. We have made available our public health expertise, as well as data and staff resources, in an effort to assist the Chancellor to design a strong and effective plan that is educationally and scientifically sound. We have pledged to work closely with the Chancellor and his staff during the implementation of such a plan. Examples of Department of Health activities include:

o The Department of Health has offered training and technical assistance to the HIV/AIDS education teams, and will continue to provide these services as HIV/AIDS education teams expand or as new training needs arise.

o The Department of Health also will make available it's Speaker's Bureau to provide speakers for meetings with groups of students, teachers, parents and/or administrators.

o The full resources of the Department's Library of AIDS Resources Division will be available to provide a vast array of teaching and informational materials. Trained staff will be available to facilitate effective usage of all these resources to supplement and expand the Chancellor's HIV/AIDS education plan.

o In addition, my Deputy Commissioner for Family Health Services) will serve on the Chancellor's Advisory Council on HIV/AIDS Education.

o With regard to other health resources, The Department of Health has been working with the Health and Hospitals Corporation, the Greater New York Hospital Association, and Adolescent Health Programs throughout the city, to assist the Chancellor's office in identifying a network of local health care providers that are interested in working with individual high schools on their expanded HIV/AIDS education programs--partnerships that could range from advisory relationships to the direct provision of health education, counseling or support services for students and faculty. We are also attempting to identify a network of providers to offer back-up medical services as needed.

o Additionally, the Department of Health, in collaboration with the Chancellor's Office, is seeking private foundation support for a plan to enable us to place highly trained health counselors/public health educators in some 35 targeted high schools across the city, who could perform a wide range of functions, such as individual and group counseling around issues of human biology, sexuality and HIV disease, including appropriate information about condom use. These public health professionals could also work closely with students and teachers with respect to the HIV education curriculum, either in direct teaching or in expanding upon issues raised but requiring further elaboration or explanation. Most importantly, they will be available to parents in the school and out in the community to discuss heath issues and build supports that adolescents desperately need -- work opportunities, mentoring and tutoring programs, and comprehensive health services.

o The Department of Health also intends to work closely with the Board of Education in the introduction of an exciting new technology--interactive video--into the classroom to support and enhance the HIV curriculum. We know that young people respond to television and movies, and that using this medium can be an effective way to reach this population. Many researchers believe that, indeed, if used effectively, television can stimulate interest in education and can help change behavior for health.

Innovative new interactive video programs are now available for AIDS, substance abuse and sex education. They have been developed with the guidance of health educators and medical specialists. Designed to engage students in important educational materials, the interactive video approach allows students to be exposed to a range of teaching lessons, as well as a series of vignettes or real-life scenarios to illustrate issues in decision-making and demonstrate to the viewer the consequences of behaviors. Because the format is active and interactive, students play close attention, and because the characters and situations come from real-life, teenagers can identify. What is more, because it can be used either individually by a student or by a teacher in a classroom as a trigger for discussion and teaching, the interactive video approach offers a stimulating and, I believe, effective mechanism to influence the knowledge, attitudes and behaviors of our city's teen in a constructive, responsible manner.

These are all the examples that time will allow, but I want you to be aware that across all aspects of the Chancellor's plan, the Department of Health has offered its expertise and resources, in both design and implementation. We are fully committed to the Chancellor's expanded HIV/AIDS education plan including condom

availability as presented before you today.

In closing, I would just like to add my strong encouragement for the Board of Education to create as many opportunities as possible for parents to be involved in this program. Parents are vitally important allies in this struggle. New York City's youth--our children--are at an unacceptable risk for HIV infection and preventable death from AIDS. We can not afford to lose a moment more. As a parent and as Commissioner of Health, I urge you as members of the Board of Education to join with me in support of this plan to educate and protect our city's youth. We must act now.

I would be happy to answer any questions you may have.

Woodrow Myers, M.D. HIV/AIDS Initiative: Strategies for Protecting New York City's Adolescents: Presentation to the New York City Board of Education. New York, NY: New York City Commissioner of Health, 1991. Used with permission.

Coalition Activities: Organizational Endorsement Form

WACHIVY members and others have been asked to support the organization's mission and petition drive. If you are a D.C. resident, please become involved by joining the coalition and by circulating copies of the petition on the reverse side of this application. If you are not a D.C. resident but have contact with residents at work or elsewhere, please help with the petition drive.
Thanks-D.C. Condom Availability Coalition.

STATEMENT OF PURPOSE:

As Organizations and individuals who are concerned with the health and well-being of the District's adolescent and young adult communities, and who are alarmed by the continued growth of the STD and HIV epidemics among adolescents and young adults, we have formed a coalition supporting the availability of condoms in DC Public Schools.

As a coalition, we are committed to promoting programs to provide:

1. Comprehensive and nonjudgemental HIV/STD prevention education presenting the range of risk-reduction options including abstinence;

2. Free and unhindered availability of condoms upon request to students in the DC Public Schools; and

3. Unbiased and nonjudgemental instruction and counseling on the correct use of condoms.

RESPONSE FORM

RETURN ASAP!!

_____ Yes, my organization agrees to sign onto the letter to Mayor Sharon Pratt Kelly supporting a condom availability program in D.C. city schools.

_____ Yes, I agree to sign onto the letter to Mayor Sharon Pratt Kelly supporting a condom availability program in D.C. city schools, as an individual (organization listed for identification purposes only.)

_____ My organization would like to join the D.C. Condom Availability Coalition.

Signature:_____ Date:_____

Please Print or type the following information:

Name:_____

Title:_____

Organization:_____

Address:_____

_____

Phone:_____

Mail to: Condom Availability Project, Center for Population Options, 1025 Vermont Ave NW #210 Washington DC 20005, FAX: 347-2263

Coalition Activities: Sample Petition

PETITION IN SUPPORT OF CONDOM AVAILABILITY

*I support comprehensive health education programs in the public schools focusing on the prevention of sexually transmitted diseases (including HIV, the virus that causes AIDS), and presenting the range of risk reduction options including abstinence.

*I believe condoms should be made available to students in the D.C. Public Schools.

*I endorse nonjudgemental counseling for sexually active youth and instruction on the effective use of condoms.

NAME-Please Print	Signature	Street Address & ZIP in DC	Ward
1.			
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19.			
20.			

Please make every effort to collect as many signatures as possible by 4/10. We encourage you to continue to collect signatures after that date as well.

RETURN TO: DC Condom Availability Coalition, c/o CPO,
1025 Vermont Ave, NW, Suite 210
Washington DC 20005
FAX: 347-2263

Coalition Activities: Sample Sign-on Letter

The Washington, D.C.

Condom Availability Coalition

1801 18th Street, N.W.
Washington, D.C. 20009

Membership (partial listing)
AIDS Action Council
ACT UP, DC
AIDS Interfaith Network
American Public Health Association
Association of Reproductive Health Professionals
Rev. Thomas Carlson, AIDS Ministry, Lutheran Social Services of the National Capital Area*
The Center for Population Options
Committee for Children
DC CARE Consortium
DC Coalition of Black Lesbians and Gay Men
DC Exchange
DC Women's Council on AIDS
Durrin Productions, Inc.
Scott Olsen, Chairman, HIV Committee, Dignity, Washington*
ENLACE
Jack Evans, DC Council, Ward 2
The Family Place
Gertrude Stein Democratic Club
Gay and Lesbian Activists Alliance
George Washington University Medical Center
David Greenberg, Chief of Clinical Operations, Hospital for Sick Children*
Anne Hall, Staff Attorney, DC Prisoner's Legal Services Project, Inc.*
Health Care for the Homeless, Inc.
Indochinese Community Center
Inner City AIDS Network
Renee Jenkins, M.D., Director of Adolescent Medicine, Howard University Hospital*
Jewish Social Services Agency
Kobe Institute
Kenilworth/Parkside Resident Management Company
Lifelink
Latin American Youth Center
Mary's Center
Mayor's Advisory Committee on Gay and Lesbian Issues
Names Project of the National Capital Area
National Network for Runaway and Youth Services
National Women's Health Network
OUT!
Pediatric AIDS/HIV Care, Inc.
Planned Parenthood of Metropolitan Washington
Program for Appropriate Technology in Health
Proyecto Ayuda
Salud, Inc.
Sexual Minority Youth Assistance League
Jonathan Smith, Executive Director, DC Prisoner's Legal Service Project
Spectrum
Silvia Silver, M.D., George Washington University Medical Center*
Teen Council of The Center for Population Options
Office of Maternal and Child Health, DHR, Department of Human Services
Reverend Stephen Tillett, Pastor, 1st United Methodist Church, Bradbury Heights*
Harry Thomas, DC Council, Ward 5
Traditional Values Coalition
Carl Vogel Foundation
Washington Area Consortium on HIV Infected Youth
Washington Free Clinic
Whitman Walker Clinic
Zero Population Growth

* Organization listed for identification purposes only

May 11, 1992

The Honorable Sharon Pratt Kelly
Mayor of the District of Columbia
District Building
1350 Pennsylvania Avenue, NW
Washington, DC 20004

Dear Mayor Kelly:

As organizations and citizens of the District of Columbia, we share your concern over the alarming rates of sexually transmitted diseases, pregnancy and HIV infection among our city's adolescents.

The threat to District teenagers is real. One fifth of all people with AIDS are in their twenties; because of the long latency period for the disease, most were probably infected as teenagers. Washington, D.C. has the fifth highest number of reported AIDS cases in the nation. A recent study of adolescent patients at Children's Hospital, conducted in collaboration with the Centers for Disease Control, revealed a five-fold increase in HIV seropositivity rates among teenagers over the four years of the study.

We believe the District must take drastic and direct action to reduce these risks to teenagers who are already sexually active. We are writing to express our support for the broad-based HIV/AIDS prevention and education program unveiled today. We are pleased that the plan emphasizes the full range of risk-reduction programs including both the promotion of abstinence and condom availability.

Several major cities -- and many smaller ones -- have taken similar steps to prevent the spread of the deadly HIV among sexually active students. Among them, actions by the New York City Board of Education have received the greatest public attention. Programs are, or will be, beginning in Los Angeles, San Francisco, Philadelphia, Portland, and Seattle. A program has been in place for two years in Commerce City, Colorado, and at least 11 communities in Massachusetts are beginning programs at the encouragement of the state Board of Education. In addition, condoms are provided to students through school-based health centers in about 40 schools across the country, including clinics in Baltimore, Chicago and Miami.

While condom availability programs are controversial the primary concern must be the future health and well-being of our young people. We congratulate your decision to move forward with a condom availability initiative as part of a broad educational effort aimed at reducing risk-taking behavior. The lives and health of our young people must be our highest priority.

Sincerely,

A list of endorsing organizations and individuals follows:

DC CONDOM AVAILABILITY COALITION MEMBERS

AIDS Action Council
ACT UP, DC
AIDS National Interfaith Network
American Public Health Association
Association of Reproductive Health Professionals
Rev. Thomas Carlson, AIDS Ministry, Lutheran Social Services of the National Capitol Area
The Center for Population Options
Committee for Children
DC CARE Consortium
DC Coalition of Black Lesbians and Gay Men
DC Exchange
DC Women's Council on AIDS
Durrin Productions, Inc.
Dignity Washington
ENLACE
Jack Evans, DC Council, Ward 2
The Family Place
Gertrude Stein Democratic Club
Gay & Lesbian Activists Alliance
George Washington University Medical Center
David Greenberg, Chief of Clinical Operations, Hospital for Sick Children
Aurie Hall, Staff Attorney, DC Prisoner's Legal Services Project, Inc.*
Health Care for the Homeless, Inc.
Indochinese Community Center
Inner City AIDS Network
Renee Jenkins, M.D., Director for Adolescent Medicine, Howard University Hospital*
Jewish Social Services Agency
Koba Institute
Kenilworth/Parkside Resident Management Company
Lifelink
Latin American Youth Center
Mary's Center
Mayor's Advisory Committee on Gay & Lesbian Issues
Names Project of the National Capitol Area
National Network for Runaway & Youth Services
National Women's Health Network
OUT!
Pediatric AIDS/HIV Care, Inc.
Planned Parenthood of Metropolitan Washington
Program for Appropriate Technology in Health
Proyecto AMOR
Salud, Inc.
Sexual Minority Youth Assistance League
Johnathan Smith, Executive Director, DC Prisoner's Legal Services Project
Spectrum
Sylvia Silver, M.D., George Washington University Medical Center*
Teen Council of The Center for Population Options
Office of Maternal & Child Health, Commission of Public Health, Department of Human Services
Rev. Stephen Tillett, Pastor, 1st United Methodist Church, Bradbury Heights*
Harry Thomas, DC Council, Ward 5
Traditional Values Coalition
Carl Vogel Foundation
Washington Area Consortium on HIV Infected Youth
Washington-Free Clinic
Whitman Walker Clinic
Zero Population Growth

* Organization listed for identification purposes only

Coalition Activities: Sample Press Release

The Washington, D.C.

Condom Availability Coalition

1801 18th Street, N.W.
Washington, D.C. 20009

Membership (partial listing)
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ACT UP, DC
AIDS Interfaith Network
American Public Health Association
Association of Reproductive Health Professionals
Rev. Thomas Carlson, AIDS Ministry, Lutheran Social Services of the National Capital Area*
The Center for Population Options
Committee for Children
DC CARE Consortium
DC Coalition of Black Lesbians and Gay Men
DC Exchange
DC Women's Council on AIDS
Durrin Productions, Inc.
Scott Olsen, Chairman, HIV Committee, Dignity, Washington*
ENLACE
Jack Evans, DC Council, Ward 2
The Family Place
Gertrude Stein Democratic Club
Gay and Lesbian Activists Alliance
George Washington University Medical Center
Dave Greenberg, Chief of Clinical Operations, Hospital for Sick Children*
Anne Hall, Staff Attorney, DC Prisoner's Legal Services Project, Inc.*
Health Care for the Homeless, Inc.
Indochinese Community Center
Inner City AIDS Network
Renee Jenkins, M.D., Director of Adolescent Medicine, Howard University Hospital*
Jewish Social Services Agency
Kaiz Institute
Kenilworth/Parkside Resident Management Company
Lifelink
Latin American Youth Center
Mary's Center
Mayor's Advisory Committee on Gay and Lesbian Issues
Names Project of the National Capital Area
National Network for Runaway and Youth Services
National Women's Health Network
OUT!
Pediatric AIDS/HIV Care, Inc.
Planned Parenthood of Metropolitan Washington
Program for Appropriate Technology in Health
Proyecto AMOR
Salud, Inc.
Sexual Minority Youth Assistance League
Jonathan Smith, Executive Director, DC Prisoner's Legal Service Project
Spectrum
Silvia Silver, M.D., George Washington University Medical Center*
Teen Council of The Center for Population Options
Office of Maternal and Child Health, DPH, Department of Human Services
Reverend Stephen Tillett, Pastor, 1st United Methodist Church, Brooklyn Heights*
Harry Thomas, DC Council, Ward 5
Traditional Values Coalition
Van Vogel Foundation
Washington Area Consortium on HIV Infected Youth
Washington Area Clinic
Whitman Walker Clinic
Zero Population Growth

* Organization listed for identification purposes only

For Immediate Release:
5.11.92

Contacts: Susan Flinn, 202.347.5700
Center for Population Options
Michael Ramirez, 202.727.6421
Mayor's Advisory Committee on Gay & Lesbian Issues
Hart Roussel, 202.797.3562
Whitman-Walker Clinic, Inc.

DC Condom Availability Coalition gains Mayor Kelly's support for Condom Availability programs in DC Public Schools and Correctional Facilities. Condom availability seen as bold step toward HIV infection control.

In a May 11, 1992 meeting with members of the broad based DC Condom Availability Coalition, Mayor Sharon Pratt Kelly pledged her staunch support for condom availability programs in the DC Public Schools and DC Correctional facilities as part of a comprehensive HIV response plan.

"The Mayor's comments and her willingness to come out strongly on this issue are both a witness to her leadership and her grasp of the magnitude of the epidemic in the city," noted Coalition co-chair Michael Ramirez. "If we are ever to get a handle on HIV and protect the well being of our youth, bold initiatives such as these must move forward".

New statistics on HIV infection in the District, set to be released May 12 as part of the Commission on Public Health's Office on AIDS Activities "Five Year AIDS Response Plan", indicate that the city is losing the battle against HIV infection. The DC Condom Availability Coalition believes that immediate and drastic action must be taken to prevent further losses in the battle to control HIV infection and other sexually transmitted diseases (STD's) particularly among the city's adolescents.

Members of the Coalition anticipate that Mayor Kelly and the Commission on Public Health leadership, Commissioner Mohammed Achter and OAA Chief Caitlin Ryan, will be criticized for supporting both abstinence and the use of protective barriers as a means of reducing rates of HIV infection. "Critics often attempt to turn this issue into an either/or debate, either moral or immoral, biblical or hedonistic. None of these sound public health recommendations is about replacing traditional values or morality with a liberal agenda," said Coalition co-chair Hart Roussel. "Rather, the unethical option is to sit by and do nothing in the face of this epidemic for fear of offending segments of the population. I'm offended by the death and devastation of this epidemic...enough is enough".

For almost a year now, citizen activists, health educators and adolescent health professionals alarmed by the seemingly unchecked spread of HIV within the District's adolescent community have worked in coalition to support condom availability in the DC Public Schools. Over 65 local health, education, and religious organizations have been joined by national organizations and professional associations in endorsing condom availability in the DC Public Schools and Correctional Facilities.

"The diversity represented on the DC Condom Availability Coalition indicates that HIV prevention, particularly among adolescents, is a concern for all segments of the District's population," stated Coalition co-chair Susan Flinn. "We know that the majority of Americans see HIV as a major health threat and support comprehensive human sexuality and HIV prevention education in the schools. We shouldn't drag our feet on this any further."

On March 11, 1992, Coalition members adopted the following statement of purpose:

"As Organizations and Individuals who are concerned with the health and well-being of the District's adolescent and young adult communities, and who are alarmed by the continued growth of the STD and HIV epidemics among adolescents and young adults, we have formed a coalition supporting the availability of condoms in DC Public Schools. As a Coalition, we are committed to promoting programs to provide:

1. Comprehensive and nonjudgmental HIV/STD prevention education presenting the range of risk reduction options including abstinence;

2. Free and unhindered availability of condoms upon request to students in the DC Public Schools; and,

3. Unbiased and nonjudgmental instruction and counseling on the correct use of condoms."

Coalition Activities: Colleague Letter to City Council Members

COUNCIL OF THE DISTRICT OF COLUMBIA
WASHINGTON, D.C. 20004

March 30, 1992

The Honorable Frank Smith
1350 Pennsylvania Avenue, N.W.
Room 122
Washington, D.C. 20004

Dear Councilmember Smith:

We are all well aware of the devastating impact the AIDS epidemic has had upon society. However, I was alarmed to recently learn that the District of Columbia now ranks first in the rate of new HIV infection among adolescents. Furthermore, more than 20 percent of all people with AIDS, including those in the District, are in their 20s. Given the average ten year period between infection and the onset of symptoms, the majority were probably infected during their teenage years.

In light of these facts, I have been working in recent months with an organization seeking to promote innovative and expanded approaches to HIV prevention. The D.C. Condom Availability Coalition was formed to promote comprehensive health education programs in the public schools which present the range of risk reduction behaviors, including both abstinence and responsible condom use.

Representatives of the D.C. Condom Availability Coalition will be contacting you in the near future. I hope you will take this opportunity to meet with the Coalition to discuss any questions or concerns you may have about their objectives. Also, please feel free to contact me if you have any questions or comments on this matter.

As always, thank you.

Sincerely,

Jack Evans
Councilmember, Ward 2

JE/jjr

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Sample Letter: Chicago Community-Based Organizations

CHICAGO WOMEN'S AIDS PROJECT
5249 North Kenmore ▪ Chicago, IL 60640 ▪ (312) 271-2070

April 16, 1992

Commissioner Sheila Lyne, RSM
Chicago Department of Health
50 W. Washington St
Chicago IL 60602

Dear Sister Sheila Lyne:

Following up on testimony given at a recent City Council hearing, we are writing to express our grave concern over the lack of condom availability in important sectors of our public health system. In the face of the most devastating pandemic in the era of modern medicine, we know that condoms and vaginal spermicides are effective in stopping HIV and/or STD infections, cervical cancer, congenital syphilis and many cases of infertility. This letter will argue that:

1. CDOH is not making available adequate supplies of condoms and spermicides to populations at risk of STD/HIV infection. Specifically, we believe that availability should be greatly increased in the STD clinics, in primary health clinics located in high-incidence community areas, in public high schools, and to CBOs involved in HIV prevention.

2. The price of condoms and spermicides is prohibitive for many low-income and young people.

3. The large-scale provision of free or subsidized prevention supplies is an extremely important and cost-effective policy decision that should be undertaken by the Department of Health immediately.

Our specific purpose in writing is to urge you as a major public health leader to speak forcefully in favor of prevention in general and for access to condoms and spermicides in particular.

(Note: We believe that condoms and nonoxynol-9 vaginal spermicide should be used in combination for protection during heterosexual intercourse, rather than just condoms alone. Vaginal spermicides with nonoxynol-9 have been found to reduce infection in the two most common STDS, gonorrhea and chlamydia, up to 75% or more. Because STD infections are a cofactor in HIV transmission, this has at least an indirect effect on the AIDS epidemic. Research has not been done on the direct effect of spermicides on HIV.

Women often tell us that they have great difficulty convincing men to use condoms. There are increasingly frequent reports of women calling AIDS hotlines to report that they have been battered after suggesting condom use. This should not be surprising when we recall that battery is the single largest cause of injury to women in the United States, more frequent than auto accidents, muggings and rapes combined. Spermicides are urgently needed as a second line of defense for women who have little power in sexual decision-making.

The combining of condoms and spermicide is usual practice at Planned Parenthood clinics and is also recommended by the standard reference work Contraceptive Technology. Unfortunately, however, the male-oriented message of "condoms-condoms-condoms" is the prevention message that is still most commonly given. For the remainder of this letter, we will use the word "condoms" when discussing lack of access to prevention supplies, but our message to you is that condoms, vaginal spermicides and lubricants are all necessary and should be supplied.)

Our projects work daily with scores of women, many HIV+, poor and African-American, and we hear a great deal about the problems they confront in trying to protect themselves. Additionally, the Chicago Women's AIDS project has an HIV educator at two important sites, the Holman Health Center and the the Municipal STD Clinic at 1306 S. Michigan (where we work closely with the extremely able and supportive CDOH staff members Dr. Jane Schwebke, Jean Richard, Collins Love and Joann Macon).

As you know, Holman is in the near-south side Oakland community area near 42nd and the lake. This area is number one in Chicago for teen pregnancy, with 35.2% of all births to teenage girls 19 and under. The area is tied for second place in rate of sexually transmitted diseases, with one STD infection per 23 residents. Holman serves approximately 3000 patients per month, and is a primary health center for residents of Robert Taylor Homes, Ida B. Wells, and several other large housing projects.

According to what we have been able to learn, Holman receives 15,552 condoms annually from CDOH, and 6000 annually from the Illinois Department of Family Planning for a per capita condom rate of .59 condoms per patient. It is true that not every patient will want or need condoms. If we calculate more conservatively, using only those seen in clinic departments that serve youthful sexually active patients (maternal, family planning and WIC), we arrive at a per capita condom rate of 1.1 condoms per person per month.

By way of comparison, a model family planning clinic at Grady Memorial Hospital in Atlanta (Atlanta's equivalent to Cook County) distributes one half-million condoms per year in its 16,000 visits. In other words, a clinic that is less than half as large has nearly 15 times as many condoms to distribute. Clinic director Dr. Robert Hatcher, the senior author of *Contraceptive Technology*, has instituted a policy of allowing each patient to take up to 160 condoms per visit. *Contraceptive Technology* states that "One important feature of successful distribution programs is the provision of large numbers (50-100) of condoms to each client. Providing three or a dozen condoms only is a short-term solution for clients who find the health care system to be inaccessible."

The high rate of STDs on the near south side is an AIDS epidemic waiting to happen. In the most recent issue of *Sexually Transmitted Diseases*, Dr. Judith Wasserheit, the director of the CDC's Division of STD/HIV Prevention, reviewed 75 studies on the relationship between untreated STDs and HIV infection. She finds a 3-5 times greater chance of transmission to persons with untreated ulcerative or nonulcerative STDs. According to a computer model developed by Dr. David Sokal, epidemiologist with AIDSTech, the presence of an untreated STD can multiply the chance of HIV tansmission by a factor of ten to 100 (AIDSTech is one of the largest HIV education organizations in the world, and has been extensively involved with HIV control in Africa).

As you know very well, STDs are rapidly increasing in many of the poorest community areas here in Chicago. Although there are many reasons for this growth, one is the crisis in the public health system. Our underfunded STD clinics turn away 20% of patients who present for care, putting them at danger and insuring that they will become loci of infection to others.

The ten community areas with the highest reported STD rates are very poor with an average median income of $13,512, and 91-99% African-American. We hear constantly from young people and poor people that the cost of prevention supplies is out of their reach. Our educators are literally beseiged when they pass out safer sex supplies. We calculate that it costs over $21 per month to purchase the recommended prevention supplies. For a woman on public aid with two children, this would consume over 6% of her monthly income. Successful social marketing programs already in practice in the Third World suggest that the price for one month's supply of contraceptives should not exceed 1% of the monthly household income of lower-income groups.

We would never dream of asking parents to spend 6% of their monthly income to buy polio vaccine for their child's immunization. Yet government agencies routinely ask people to make such an expenditure for safer sex supplies. Why the difference? We believe it is because HIV prevention is still approached as a question of moralism, not as a public health issue. In our society sexuality is still veiled in a culture of silence. To insure access to prevention supplies would be to admit that sexuality is a natural part of our lives. Decision-makers do

not want to supply condoms because they believe this will "send the wrong message that they condone sexual activity." Those who have sex are somehow "guilty" of willfully exposing themselves to danger. We would submit that such punitive thinking cannot be the basis of public health policy in the case of a volatile and rapidly-expanding epidemic of a fatal disease.

We realize that the CDOH is not the only level of government responsible for problems in access to prevention supplies. In our search for larger supplies of condoms, a number of government representatives have told us directly that "the condom issue is too hot to handle." A highly-placed person in the Illinois Department of Health told us that "No politician wants to be seen as supporting condoms, so the funding is just not available. You'll have to take your request to the feds." When we took our request to the federal government, another official cautioned, "Be careful you don't get known as 'that condom project.'" Dr. Robert Hatcher pointed out the sobering reality that large-scale federally-funded HIV prevention projects are often only minimally supplied with condoms. We know of one such prevention project which has actually been forbidden to buy condoms on its grant. We believe that decision-makers are putting political considerations ahead of people's lives. Federal, state and city governments should be in the forefront of assuring condom accessibility, not fueling the epidemic by withholding what is figuratively the only "vaccine" available.

In terms of condom availability in public high schools, Chicago is moving rapidly in the wrong direction. This issue is important because several surveys show that teenagers most frequently cite the unavailability of condoms as a barrier to safer sex practices. To our knowledge, the high point of condom availability through the Chicago Public Schools was in 1989-90, when 7000 condoms were available through the Family Life Education program. Since that time the Board of Education has withdrawn 100% of its financial support for the program, so that today zero condoms are made available to students (with the exception of those who attend the three schools having school-based clinics). According to the information we have available, CDOH currently only gives 4000 condoms annually to the school district for teacher training purposes.

By contrast, New York's exemplary new condom availability program currently makes available 79,000 condoms monthly to the district's 265,000 high school students. When the program becomes fully operational in the fall of 1992, the goal is to give out one quarter of a million condoms per month (.94 condoms per capita/mo.). It is important to note that New York's model condom availability program was won only after a major organizing effort involving thousands of concerned parents, students, and HIV educators. Schools Chancellor Joseph Fernandez vigorously fought for the program, embracing controversy in order to confront the frightening escalation of HIV infection among teens in New York.

Lastly we want to address condom availability for the community based organizations, which play a vital role in reaching people at greatest risk. We realize that various CBOs have diverse sources of funding; perhaps because many funders are reluctant to fund prevention supplies, the net result is that most CBOs have far too few supplies to work with. We can cite the example of Genesis House, which is Chicago's main project focused on sex workers. In some instances, outreach staff must give a sex worker only three condoms to last until four days later, when the woman sees an average of ten customers each day. Another project works in an area where children must step over addicts to get to school. A very dedicated health educator working in the neighborhood lamented, "I remember seeing a condom about six months ago." When great efforts are made to reach hard-to-reach high-risk individuals, certainly it is a tragically misguided economy measure to hold back on providing supplies that are so urgently needed for concrete behavior change. As someone aptly said, "No one has ever been saved from HIV infection by a brochure alone."

It is our understanding that those CBOs with a CDOH contract may pick up one or two boxes of 1000 condoms per month. Others, if they know about the program, receive whatever is available and must request condoms through the time-consuming procedure of submitting a letter each month and then picking up whatever is available in the Loop, a procedure that can take hours of staff time. We look forward to a meeting between the CBOs and CDOH to streamline the process of distribution.

Dr. Hatcher tells the story of one man in Egypt, who traveled for one and a half hours up the Nile by boat to a family planning clinic. The man, who relied on condoms for his primary method of birth control, was issued two condoms before beginning his trip home. While this story is shocking, we may ask if our public health clinics do much better. Patients at our underfunded STD clinics must often wait 4-6 hours to be seen; they frequently spend $2.50 or more on public transportation. According to the information available to us, the usual number of condoms given to the very high-risk population at the STD clinics is three to five.

Our commitment to condom availability flows from a commitment to prevention. Unfortunately the US health care system is oriented toward cure over prevention. One young woman we know got reinfected with STDs seven times. As she came in for her medication time after time, no discussion or information on safer sex was provided. Even if the only issue were dollars, instead of human lives, the curative approach would be totally irrational. For instance, it costs an estimated $00 million annually to treat gonococcal pelvic inflammatory disease, just one complication of one subcategory of STD. This is 15 times the entire federal prevention and surveillance budget for STDs. It might be worthwhile to find out what Cook County pays out for treatment for PID annually, and then compare this to our budget for condoms and spermicides. At recent City Council hearings on AIDS, PWA Jim Lenk dramatized the importance of prevention by setting out a pile of his own

medical bills totaling $295,298.79, a sum that could purchase nearly five and a half million condoms.

Many clinics in the Third World have made systematic efforts to incorporate safer sex education into regular clinic protocols to help address the "revolving door" syndrome of frequent reinfection. The Chicago Women's AIDS Project has worked very well with CDOH personnel to attempt to move in this direction, and we believe that these initial efforts could be further strengthened.

We said in the City Council hearings that we need to look at Africa to see the devastation this epidemic is capable of wreaking under conditions of poverty and a weak health infrastructure. The CDC reported that half the adult population of Uganda will be dead within eight years. According to some researchers, one fourth of the workforce of Africa will be eliminated by the year 2010. Dr. Jonathan Mann points out that the seroprevalence rate in parts of the South Bronx are already equivalent to the worst rates in Africa. The leading US experts on sexually transmitted diseases point out that the STD epidemic here has all the characteristics of an epidemic in the Third World. When we look at Africa, we are staring at the future of America's inner cities...unless we take decisive action.

We hope that you, as the top public health leader in the third largest city in the United States, will help galvanize this determination by speaking and acting for wider access to prevention supplies. Condom availability is controversial because it is a tangible symbol that interrupts the culture of silence around sexuality. We simply cannot afford the silence any longer, for at this stage in the epidemic, our children may pay for our politeness with their lives.

In closing, we hope that you will speak in a strong voice for the importance of prevention in general and specifically for greater accessibility of condoms and other supplies. Condoms and spermicides must become as ordinary as seat belts. We must begin to talk openly about safer sex in our clinics, in our schools, in our communities, in our families and with our partners. As we see in the example of Joseph Fernandez, such willingness to embrace controversy and provide clear leadership can make a tremendous difference.

Sincerely,

Vicki Legion, Project Coordinator, CWAP

Catherine Christeller, Executive Director, CWAP

Mardge Cohen, MD, Director, Women and Children with HIV Program, Cook County Hospital

Involving Youth: Sample Testimony

TESTIMONY OF RACHEL REINHARD TO THE COMMITTEE ON PUBLIC HEALTH, CITY COUNCIL, WASHINGTON, D.C.

My name is Rachel Reinhard, and I am a 1992 graduate of Wilson High School, and a summer employee at the Washington Area Consortium of HIV Infection in Youth (WACHIVY). I am speaking to you today as a member of the Center for Population Options' Teen Council. I would like to commend the commission on their bold and aggressive initiative to make condoms available to the city's sexually active high school students. This action may not, and probably will not, eliminate the cases of HIV, teen pregnancy and other STD's among this city's youth; but it will surely be a first and most important step in reducing the prevalence of these threats to the strength and viability of this generation: my generation.

With this initiative the city is finally looking realistically at a problem that can not be solved by a "Just Say No" campaign. It is a sign that the city's leaders view young people as complex individuals who will not be swayed by a trite message but may more often than not be touched by a realistic, multifaceted campaign providing resources and information that will affect change, not just for today or tomorrow, but for the duration.

What I ask of you today is not to kill this program before it even begins. To stick with it no matter what pressure you may come under. I also implore you to include teens in every aspect of the planning and implementation. Because if you don't look for our reaction or our wants we will not utilize this program and it will not work. You must learn how we speak, how we think, and what is the best and most effective way to reach us. It is your responsibility to educate you. Our attitudes, beliefs and behaviors should be of you greatest concern right now. If you cannot understand us now, you will not understand us in September when the school nurse sits that first student down in her office.

Don't speak of protective barriers but of condoms and rubbers. Talk to us not of a virus that enters the blood stream, but of a disease that will cripple our lives and leave us dead before life has really begun. Tell us of potential, provide us with tools, and made us believe that we can realize it. Let us know that our destiny is not a jail cell, maternity ward or quarantined room. Speak to us of a future that is bright and tantalizing and then prepare us for it.

You and your peers have done your best to ostracize us from the political structures of this country and it is now up to you to win us back. We are your future and we will not be toyed with any longer. It is time that the needs of this threatened population are addressed fully, openly and without censorship. We live day to day under the constant threat of wanton violence and you must make us understand that we still need to live for each day and for the next. We must be taught that there is a future and how best to protect it. Give us a reason to live and we will grab it.

Today, I feel that the most powerful and influential people in this community of Washington, DC are finally beginning to realize what the youth -- my friends, classmates and I -- have known for some time. That we, teenagers, are thinking thoughtful members of this city and this nation; that we will not disappear and cannot be shoved to the fringes of society. We are nobody's leftovers. We are an exciting and dynamic population that must be preserved. The components of the city's five year plan directed at teenagers indicate that the policymakers in this city are beginning to understand this, and that a unified effort by students, parents, teachers, administrators and public officials together is the means by which we can eventually begin to chip away of this overwhelming burden of death that is HIV.

Involving Youth: Student Petitions

STATEMENT ON PRESENTING TEEN PETITION TO MAYOR, WASHINGTON, D.C., BY ADINA MADDEN

Good morning. My name is Adina Madden and I am a student enrolled in the D.C. public school system. I speak here today on behalf of the members of the Center for Population Options' Teen Council and all adolescents concerned with the sudden increase in the number of HIV/STD infections and unwanted pregnancies among youth.

First, we would like to applaud Caitlin Ryan, the Director of the Office of AIDS Activities, Dr. Mohammed Akhtar, the Commissioner of Public Health, Mayor Sharon Pratt Kelly, and anyone else instrumental in getting the 5-year AIDS plan to the forefront. In conjunction with this proposed five year health plan, we wish to see this ever increasing problem remedied through a comprehensive HIV/AIDS curriculum, which would include making condoms available to the District's sexually active youth.

We believe that by making condoms, counseling, and instruction available to sexually active youth, you are promoting safe and responsible behavior. We do not feel that having condoms available in the District's public high schools would send mixed messages or promote promiscuity. By creating and supporting such a bold statement, you are not only alerting youth that there really is a crisis, but also showing them that you care.

We understand that this issue would have many political and bureaucratic ramifications, but our future is at stake! Everyday that policy makers debate the morality of this issue, teens are having sex. Many teens will contract a sexually transmitted disease or have an unwanted pregnancy. Many will also become infected with HIV, the virus that causes AIDS. These teens are not only your children, nieces and nephews, neighbors and students, but also our future. A clear and resounding statement of support for the health of our youth must be made.

It has been proven that many teens in the District are sexually active. As a teen, I feel that the adults will not be able to change our behavior through senseless rhetoric. You can help make these decisions more responsible and safe by making these lifesaving devices available to sexually active youth. We have enough barriers that separate us youth from a safe and certain future. We teens of Teen Council also applaud Mayor Kelly's efforts in establishing the Youth Crime Initiative, in which condom availability can be an essential component.

In recent weeks, members of the Center for Population Options' Teen Council conducted a petition drive in the D.C. public schools. Over 1600 high school students signed the petition that we are presenting to you today. The following schools are represented: Woodrow Wilson, Duke Ellington, Benjamin Banneker, Bell Multicultural Center, McKinley, Spingarn, Roosevelt, Eastern, Chamberlain, School Without Walls, Dunbar, M.M. Washington and H.D. Woodson.

The statement they signed reads as follows:

We, the students of Washington, D.C.'s pubic high schools, recognize the growing numbers of teen pregnancies and STD infections, including HIV, in our community. We recognize these statistics as a health crisis among adolescents and believe that sexually active students should be given information as well as the means to protect themselves. Therefore, we strongly support condom availability in the D.C. public schools as one component of a comprehensive education curriculum.

We commend you for including condom availability in the five year plan and urge swift actin to implement this plan as soon as possible. Together, we can make this work.

CPO 1993--ATTACHMENT 111.3.3

B. Condom Hunt

Purpose:
- To provide young people with the opportunity to obtain a condom without pressure; to develop a list of accessible places where teens can obtain condoms; to help teens develop the skills to protect themselves.

Materials:
- If desired, "Condom Hunt Survey" worksheet for each teen (next page).

Time:
- 10 minutes - to introduce

Planning Notes:
- Decide whether you want teens to obtain condoms or to complete the survey in writing.

Procedure:
- Ask the teens to go to a drug store, grocery store or convenience store and purchase a package of condoms. Stress that condoms should be latex and preferably treated with a spermicide containing nonoxynol-9. Tell them you will collect all condoms to use as instructional samples. (If possible, you can reimburse students for condoms.)
- Many communities have health departments, community or free clinics which distribute condoms without charge. Giving out the location or phone number of local resources could help teens obtain condoms free of charge. Be sure to tell the teens that there is no assumption that they are having sex or need condoms now. Rather this assignment will help young people in the future and might help a friend.
- If you choose to ask the teens to complete the worksheet instead of obtaining condoms, distribute the "condom hunt" worksheet to each teen, discuss what each question means, and ask them to return the completed worksheet for Session VIII.

Condom Hunt

Name of Store _____ Drugstore ____ Other ____

Address _____ Date Completed _____

Store Hours _____ Time Into Store _____

Name of Observer _____

ACCESS

1. Are there any signs in the store to identify family planning items? ___ Yes ___ No (go to 1a.) (go to 2.)
   a. If yes, what does the sign say? _____
   b. Time found: _____
   c. Are all the family planning methods in one place? ___ Yes ___ No
2. If there is not a sign, what method(s) did you find first:

   _____
   a. Time found: _____
   b. Are all the family planning methods in one place? ___ Yes ___ No

EMPLOYEE INTERACTION: "Can you please tell me where the condoms are?"

Employee: ___ Male ___ Female

Response to question: ___ Positive ___ Negative

LOCATION

3. Where are the condoms located: (CHECK ONLY ONE)
   - __ behind the Pharmacy counter
   - __ by the Pharmacy counter
   - __ behind the check-out counter
   - __ by the check-out counter
   - __ with feminine hygiene products
   - __ with men's personal hygiene products
   - __ family planning section
   - __ Other
4. Does the store have the following kinds of condoms:

Lubricated	___ Yes	___ No	___ Don't know
Non-lubricated	___ Yes	___ No	___ Don't know
With spermicide nonoxynol-9	___ Yes	___ No	___ Don't know

What is the lowest price for one package of three lubricated condoms?

Price: _____ Brand: _____

5. Where are the other family planning methods located? (CHECK ALL THAT APPLY)

___ behind the Pharmacy counter
___ by the Pharmacy counter
___ behind the check-out counter
___ by the check-out counter
___ with feminine hygiene products
___ with men's personal hygiene products
___ family planning section
___ Other

6. Does the store have the following kinds of family planning methods?

Foam	___ Yes	___ No	___ Don't know
Jelly	___ Yes	___ No	___ Don't know
Cream	___ Yes	___ No	___ Don't know
Sponges	___ Yes	___ No	___ Don't know
Suppositories	___ Yes	___ No	___ Don't know

7. Do they have pamphlets or information on STDs and/or AIDS in the store?

___ Yes ___ No (IF YES, take a sample with you)

Time Out Of Store: _____

Notes:

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ATTACHMENT III.H.1

Sample Legislation: Boston City Council

ORDINANCES OF 1992 - CHAPTER --

CITY OF BOSTON

IN THE YEAR NINETEEN HUNDRED AND NINETY-TWO

AN ORDINANCE

TO HELP FIGHT THE PUBLIC HEALTH CRISIS
OF STD'S INCLUDING AIDS

Be it ordained by the City Council of Boston, as follows:

WHEREAS, Two-hundred and fifty (250) new cases of AIDS were reported in Boston during 1991, with fifty (50) new cases reported in May of 1992; and

WHEREAS, 10,891 cases of chlamydia, 5983 cases of gonorrhea, and 1394 cases of syphilis were reported in Massachusetts in 1991; and

WHEREAS, The continued transmission of these sexually transmitted diseases constitutes a public health emergency for the City of Boston; and

WHEREAS, The risk of transmission of all of these sexually transmitted diseases can be greatly reduced through the use of latex condoms; and

WHEREAS, It has been shown that wider availability of condoms can help decrease the incidence of sexually transmitted diseases; and

WHEREAS, Further availability of condoms in establishments with entertainment licenses will send a message of responsibility to all segments of society; Now, therefore, be it

AN ORDINANCE

ORDAINED by the City Council of the City of Boston as follows:

Chapter 17-13 of the City of Boston Code is hereby amended by adding the following new sections, to be appropriately numbered by the City Clerk:

Prevention of Sexually Transmitted Diseases

Section 1. <u>Declaration of Public Health Emergency</u>

The spread of sexually transmitted diseases (STDs), including acquired immune deficiency syndrome (AIDS) and Human Immunodeficiency Virus (HIV) infection, has created a public health emergency. The spread of these diseases can be limited through the availability of affordable, high quality latex condoms in certain places of public accommodation. The lack of availability of condoms in these places of public accommodation constitutes a danger to public health and welfare.

Section 2. Requirement of Vending Machines Which Dispense Condoms

A. In order to be granted an annual seven-day entertainment license from the Licensing Division of the Mayor's Office of Consumer Affairs and Licensing, establishments which also hold a Common Victuallers seven-day all alcohol license must install and maintain coin-operated vending machines which dispense affordable, high quality latex condoms. Current holders of annual seven-day entertainment licenses from the Licensing Division of the Mayor's Office of Consumer Affairs and Licensing which also hold a Common Victuallers seven-day all alcohol license must install and maintain coin-operated vending machines which dispense affordable, high quality latex condoms in order to continue to be licensed.

B. The condom vending machines shall be located in a publicly accessible place, or in at least one male and one female rest room, and shall display a sticker prepared by the Commissioner of Health and Hospitals, which will provide telephone numbers for referral and information concerning STDs, including AIDS.

C. For the purposes of this ordinance, a "high quality latex condom" means a condom which is made of latex, a specific type of rubber product that has no pores, and which is tested and approved by the U.S. Food and Drug Administration.

Section 3. List of Vending Machine Operators

The Licensing Division of the Mayor's Office of Consumer Affairs and Licensing and the Commissioner of Health and Hospitals shall maintain a list of vending machine operators who agree to install and maintain the vending machines in continuous working order at no cost to the owners or lessees of the licensed premises.

Section 4. Exemptions

A. This ordinance shall not apply to any annual seven-day entertainment license holder whose establishment is not required to have a rest room.

B. This ordinance shall not apply to any annual seven-day entertainment license holder whose establishment has a legal maximum occupancy of less than one-hundred persons.

C. This ordinance shall not apply to any annual seven-day entertainment license which is held by a religious institution or an organization affiliated with a particular religion.

D. This ordinance shall not apply to any annual seven-day entertainment license holder whose establishment is required to obtain the license solely due to the use of automatic amusement devices on the premises.

E. This ordinance shall not apply to any annual seven-day entertainment license holder who demonstrates to the satisfaction of the Licensing Division of the Mayor's Office of Consumer Affairs that, despite the holder's good faith efforts, no vending machine operator is willing to install a condom vending machine on the licensed premises.

F. This ordinance shall not apply to any annual seven-day entertainment license holder who demonstrates to the satisfaction of the Licensing Division of the Mayor's Office of Consumer Affairs that high quality latex condoms and information concerning STDs, including AIDS, are readily available to patrons on the licensed premises.

Section 5. Annual Report to the City Council

The Licensing Division of the Mayor's Office of Consumer Affairs and Licensing shall determine whether holders of annual seven-day entertainment licenses comply with this ordinance, and shall report its findings annually to the City Council for any necessary action.

Section 6. Severability

The provisions of this ordinance are severable and if any provision shall be held to be unconstitutional or otherwise invalid by any court of competent jurisdiction then such provision shall be considered separately and apart from the remaining provisions of this ordinance which shall remain in full force and effect.

In City Council October 28, 1992. Passed, yeas ten, nays three.
Presented to the Mayor October 30, 1992.
Returned disapproved November 12, 1992.
In City Council December 2, 1992, passed notwithstanding the disapproval of the Mayor, yeas nine, nays three.

Attest: Patricia J. McConaughy

City Clerk

Sample Legislation: Resolution Declaring National Condom Awareness Week

102D CONGRESS
2D SESSION

H. J. RES.

IN THE HOUSE OF REPRESENTATIVES

Mr. WEISS introduced the following joint resolution; which was referred to the Committee on _____

JOINT RESOLUTION

Designating the 8-day period beginning on February 14, 1992, as "National Condom Awareness Week".

Whereas more than 200,000 individuals in the United States have been diagnosed as suffering from acquired immune deficiency syndrome;

Whereas the Centers for Disease Control estimate that 1,000,000 individuals in the United States currently are infected with the human immunodeficiency virus, the virus that causes acquired immune deficiency syndrome;

Whereas acquired immune deficiency syndrome has claimed the lives of more than 130,000 individuals in the United States since 1980;

Whereas latex condoms, when they are used properly, are the most effective method after abstinence of preventing the spread of sexually transmitted diseases, including infection with the human immunodeficiency virus;

Whereas the population of the United States is growing faster than the population of any other industrialized nation;

Whereas such population growth is due in part to barriers that prevent or impede access to contraceptives;

Whereas condoms are available without a prescription, are inexpensive, and have no side effects;

Whereas 3,400,000 unplanned pregnancies occur each year in the United States;

Whereas condoms, when they are properly used, are effective in preventing unplanned pregnancies, and thus reduce

Whereas recent data suggest that 72 percent of high school seniors in the United States engage in sexual intercourse;

Whereas teenagers who are sexually active have a high risk of contracting or transmitting sexually transmitted diseases, including infection with the human immunodeficiency virus;

Whereas the birthrate among 15- to 17-year-old teenagers increased 20 percent between 1986 and 1989;

Whereas, each year, 1,000,000 teenagers in the United States become pregnant;

Whereas 84 percent of such pregnancies are unplanned;

Whereas teenagers who are sexually active have a high risk of experiencing or causing unplanned pregnancies; and

Whereas the awareness and proper use of condoms can contribute significantly to the prevention of unplanned pregnancies and the transmission of diseases, including infection with the human immunodeficiency virus, among adults and teenagers: Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That the 8-day period beginning on February 14, 1992, is designated as "National Condom Awareness Week", and the President is authorized and requested to issue a proclamation calling on the people of the United States to observe the period with appropriate ceremonies, educational activities, and programs designed to increase public awareness regarding the availability and proper use of condoms, and to increase public recognition that proper use of condoms can prevent pregnancy and the transmission of diseases, including infection with the human immunodeficiency virus.

National Condom Awareness Week was endorsed by the following organizations:

AIDS Action Council

American College Health Association's Task for on HIV Disease

American College of Obstetricians and Gynecologists

American Council on Rural Special Education

American Public Health Association

Association of Reproductive Health Professionals

The Center for Population Options

The Hetrick-Martin Institute

Human Rights Campaign Fund

National Coalition of Advocates for Students

National Coalition of Hispanic Health and Human Service Organizations

National Family Planning and Reproductive Health Association

National Lesbian and Gay Health Foundation

National Rural and Small Schools Consortium

National Women's Health Network

Planned Parenthood Federation of America, Inc.

Population Crisis Committee

Sex Information and Education Council of the United States

The Teen Council of The Center for Population Options

U.S. Conference of Local Health Officers

U.S. Conference of Mayors

Zero Population Growth

Condoms in Schools: The Right Lesson

By Paul Epstein

CAMBRIDGE, Mass.

Does the distribution of condoms, as has been proposed for New York City's schools, encourage and condone sexual promiscuity? A growing body of research and the experience of AIDS educators suggests just the opposite: Condom availability, combined with AIDS education, can delay and discourage casual sexual activity.

Researchers at the Johns Hopkins Medical School conducted an AIDS education program in Baltimore that included condom distribution in a high school. They found an increased number of students choosing to abstain from sex, and a significant delay in the onset of first sexual activity among the students.

Other studies in progress are finding similar results. At a recent hearing in Cambridge, an AIDS counselor testified that since the distribution of condoms began in his program for runaway youth, clients report having fewer sexual partners. He also reported that the youngsters discussed the risks of AIDS more frequently, revealing their deepening concern.

My own interviews with adolescents and college students suggest that the presence of condoms makes them more wary of casual sex, more conscious of the epidemic and more serious about their own risk.

The Centers for Disease Control consistently reports that teen-agers are at high risk of AIDS transmission; the growing number of young HIV positive persons substantiates this. Recent high school surveys demonstrate that more than 80 percent of students have full knowledge of the means of AIDS transmission, but only one-quarter to one-third are actually practicing safer sex.

If responsible adults and officials don't take the initiative in protecting students from the risks of unsafe sex, the students will take the lead. In 1989, a class of Cambridge High School students trained as peer educators began distributing condoms to fellow students. After a series of well-publicized hearings (in themselves an education for the community), the Cambridge School Committee ruled that condoms could be distributed through the Teen Clinic at the school.

Subsequently, the Cambridge City Council enacted an ordinance requiring most public establishments to provide condom vending machines along with AIDS education brochures. The Massachusetts Department of Public Health has now taken a leading role, with public advertisements and condom distribution. It's too early to have data to judge results; such experiments should be taking place all over the country.

Kids think twice about taking risks.

Some oppose distributing condoms in the schools because, they say, it will mislead students into believing there is such a thing as "safe sex." Are condoms reliable? The March 1989 Consumer Reports found that only 1 in 165 condoms breaks during vaginal intercourse; 1 in 105 during anal intercourse. Other surveys have reported higher breakage rates and they should not be dismissed: A thorough review is needed by Federal health authorities, followed by a strict regulatory process.

Latex condoms, which account for 95 percent of the commercially available condoms, do however provide a true barrier to the AIDS virus. When used properly and combined with a lubricant containing Nonoxynol-9, they significantly reduce viral transmission. Additionally, condoms provide protection against other sexually transmitted diseases. While a small risk of transmission remains for the individual, condoms are our most effective "vaccine" to date to interrupt the spread of AIDS in our population.

And as a deterrent, their omnipresence will be a "red flag," a constant warning of the health threat we all face. Public health research has demonstrated that people, especially those with low self-esteem, resist being told to change their behavior. If however, a health benefit (for example, vaccinations) is widely available, people will utilize it in spite of holding on to their traditional attitudes.

Condom distribution programs in high schools contribute significantly to AIDS education and behavorial change. Certainly health and educational institutions should lead the way in helping to create a new culture of responsible relationships, and thus reduce the transmission of AIDS.

Paul Epstein, a doctor and instructor of medicine at Harvard Medical School, is chairman of the Cambridge AIDS Task Force.

January 20, 1991

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The Washington Post

Linda W. Cropp

To Save Our Children's Lives

We must demand the placement of condoms in our schools.

As the mother of two teenage children, I am strongly in favor of abstinence for teenagers. It is the only foolproof way I know of to avoid unwanted pregnancies and infection with HIV, as well other sexually transmitted diseases.

But I am also a realist. Aside from abstinence, latex condoms, when properly used, are the most effective method for reducing the risks associated with unprotected sex. I cannot, in good conscience, tell my children and yours just to abstain from sexual activities, because the facts speak loudly and clearly that sexual activity among teenagers is increasing and that they are not protecting themselves. Many will be infected with HIV and, unless a cure is found, will die from AIDS.

A recent report from the Centers for Disease Control indicates that 70 percent of all teenagers are sexually active by the 12th grade. More than a million teenage girls become pregnant in the United States each year. Some 2½ million young people become infected with sexually transmitted diseases by age 21 each year, and more than 800 teenagers have AIDS. One fifth of all people with AIDS are in their twenties.

Considering that the latency period between HIV infection and the onset of symptoms is about 10 years, it is truly frightening to imagine the number of teenagers who are putting themselves at risk for AIDS right now, and will probably have the AIDS virus when they reach their twenties. Here at home, the facts are even more alarming. The District is ranked fifth in the nation for number of AIDS cases per 100,000 people. It also has the highest rate of new AIDS infection and the highest rate of teen pregnancy in the nation.

Opponents of free condoms in the public schools say this measure sends a mixed message to our youth, that we are sanctioning sexual activity when the thing most of us really want as parents is for our young people to practice abstinence. As I stated at the outset, I am a strong supporter of abstinence, but for many of our youth, it is not enough to tell them to just say no.

Yes, we must teach them that it is preferable to abstain from sexual activity as teenagers, but we must also tell them that if they are sexually active they need to take precautions to protect themselves. They must act responsibly. Our children are bombarded by television and radio with the message that sexual activity is glamorous and exciting. It is up to us to provide some balance to this one-sided message, to teach our children the risks, responsibility and dangers of unprotected sexual activity.

Abstinence is preferable, but AIDS kills. To save our children's lives, we must allow—no, demand--the placement of condoms in our schools. A majority of teenagers polled say that they engage in unprotected sexual activity because they cannot afford to buy condoms or are too embarrassed to request them from strangers. Making condoms available free of charge in the public schools will provide children with guidance from teachers and counselors with whom they are familiar and provide them with the means to protect themselves.

When I served on the D.C. school board from 1979 to 1980, I advocated dispensing condoms in the schools. Unfortunately, we lost that fight. Back then, our focus was largely birth control. Today, as we are forced to revisit this issue, the stakes have gotten even higher—our focus is the AIDS epidemic, and we are trying to save the lives of our children.

Making condoms available in our public schools, as Mayor Kelly plans to do, is not a panacea for the AIDS epidemic. It is merely one component in the battle for our children's lives. If we are truly interested in reducing the risk of unprotected sex for our young people, we must utilize all the tools at our disposal. That means advocating abstinence, teaching family planning and sex education and ensuring access to condoms for sexually active teenagers.

The writer is an at-large member of the D.C. Council.

WEDNESDAY, MAY 13, 1992

(c) The Washington Post.

Sample Advertisement, New York City

WILL THE N.Y. SCHOOLS' CONDOM PLAN EXCLUDE THE TEENAGERS IN THE GREATEST DANGER?

ONLY days before it's to go into effect, the NYC Board of Education's thoughtful AIDS prevention plan is in grave danger.

The result of 18 months of public discussions among parents, teachers, and students, the plan concentrates on counseling and education. It also gives teens who are already sexually active access to condoms, to slow the spread of the virus — and save lives.

The condom plan is vital to the entire effort.

And it obviously won't work if teens in the greatest danger — those whose sexual activity is "hidden," even from their parents — are refused access to condoms.

Yet now, at the very last minute, Board of Education members who have opposed the plan from the very beginning have introduced an "opt out" amendment to grant parents veto power, stalling the plan's implementation indefinitely and risking the lives of teens city-wide.

The fact of life is that up to 80% of teens are already sexually active, whether parents know it or not. To make condoms available within the context of comprehensive counseling and education (something teenagers *can't* obtain at their local pharmacy) is essential.

70% OF NEW YORK PARENTS SUPPORT THE CONDOM PLAN. THE FEW DEMANDING THE PRIVILEGE TO "OPT OUT" ARE RISKING THE LIVES OF THEIR TEENS... AND YOURS...

Research proves that making condoms available does *not* increase sexual activity among teens. It does make sex safer and reduces the risk of teen pregnancy. With HIV infection skyrocketing among New York City's high school students, this public health emergency must be met without any further equivocation.

The two Board members below will gut New York's anti-AIDS plan if they back away from their favorable February votes and join the "opt out" forces at the Board's September 11 meeting. They must be reminded that "parental control" is not the issue. Parents have been part of the process all along and will continue to play a central role. Indeed, the vast majority of New York parents wholeheartedly *endorse* the condom plan.

Teens must be allowed to make safe, responsible choices. Lives are at stake. Please mail the coupons. Now.

Among the organizations which oppose "opt out" and support the plan approved by the Board of Education in February:

Advocates for Children of New York
AIDS and Adolescents Network of New York
AIDS Center of Queens County
Body Positive
Bronx AIDS Services
Brooklyn Teen Pregnancy Network
Citizens' Committee for Children of New York
Community Health Project
East New York HIV Project
City Men's Health Crisis
Lower Manhattan AIDS Task Force
Minority Task Force on AIDS
Planned Parenthood of New York City
South Bronx Neighborhood AIDS Project
The Henry Street Institute
Village Nursing Home AIDS Programs
Women's City Club of New York
Young Adult Institute

This ad is sponsored by The Emergency Task Force on HIV/AIDS Education, 121 6th Avenue, 6th Floor, New York, NY, 10013. It has been paid for with private contributions.

Nilda Segarra
c/o New York City Board of Education, Rm. 1130
110 Livingston St., Brooklyn NY 11201

The "opt-out" proposal is dangerous and unpractical. Follow through on your February vote. Protect those at greatest risk. The anti-AIDS plan must go into action as written. We have lost too much time already.

NAME

ADDRESS

Wenona Matthews
c/o New York City Board of Education, Rm. 1126
110 Livingston St., Brooklyn NY 11201

As a New Yorker who shares your profound concern about babies born with AIDS, I urge you to resolutely defend the condom availability plan from those who would "opt out" the very teenagers in the most danger.

NAME

ADDRESS

Reprinted with permission.

CPO 1993--ATTACHMENT III.K

FAMILIES CONCERNED ABOUT AIDS

For Immediate Release
February 5, 1990

Contact: David Eng
212-807-6664

COALITION REINSTATES RADIO AD CAMPAIGN CALLING ON BOARD OF ED VOTE FOR CHANCELLOR'S AIDS PREVENTION PROGRAM

Families Concerned About AIDS (FCAA), a coalition of AIDS service and family health organizations, is reinstating today the previously cancelled radio ad campaign rallying support for Schools' Chancellor Joseph A. Fernandez's HIV/AIDS education initiative. With a new hearing on the plan scheduled to take place Wednesday, February 6, FCAA is running the radio spots February 5, 6 and 7 on nine major New York radio stations - WQXR, WNCN, WINS, WABC, WBLS, WLIB, WSKQ-AM, WSKQ-FM and WADO-AM - to emphasize the importance of and the need for the Board to immediately vote for and approve the Chancellor's AIDS program as presently proposed.

Designed by Tony Schwartz - creator of the famous commercial that pictured a young girl plucking a daisy in one instant and in the next instant showed the mushroom cloud of a nuclear explosion - one radio ad urges all concerned parents to phone in support for the Chancellor's AIDS program. Another ad calls on members of the Board of Education to vote for the plan, saying: "Your decision to vote for this program will save lives. Does anything else matter?" FCAA pulled the radio spots originally in January following the Board's announcement that it was delaying a public hearing and postponing the vote to decide the fate of the Chancellor's plan. Although no date has been set for the vote, FCAA members charged that any further delay in implementation of Fernandez's proposal would deprive the city's youth of essential life-saving information. "It is imperative that the Board vote for the program because we are talking about the lives of our young people," said Diane Arneth, Chair of the Board of Directors of the Staten Island AIDS Task Force. "The Chancellor's comprehensive approach to AIDS prevention for a population most experts agree is the next wave of the epidemic can only be supported and encouraged by those who care about the youth and future of this city."

FCAA is an ad hoc coalition of AIDS and family health organizations created to support Chancellor Fernandez's HIV/AIDS prevention initiative.

FAMILIES CONCERNED ABOUT AIDS

BOARD OF EDUCATION SPOT

Members of the Board of Education...you have a very difficult decision on your hands.

You'll vote on a program that, for thousands of New York City teenagers, could mean life or death.

It's a program of AIDS counseling and education, to be conducted in City high schools...a prevention program where parents and teachers work together.

A program that would also include condoms.

Yes, in a perfect world, we wouldn't need AIDS counselling for teenagers.

But the world isn't perfect - just look at the facts:

An estimated 40,000 teens in New York City are now infected with the virus which causes AIDS...and most don't even know it.

Members of the Board of Education...we know it's a tough decision...

But one thing is clear: your decision to vote for this program will save lives.

Does anything else matter?

Brought to you by the Families Concerned About AIDS.

Brought to you by Families Concerned About AIDS.

Call 718-935-3300.

Families Concerned About AIDS. Board of Education Spot. New York, NY: Families Concerned About AIDS, 1991. Used with permission.

FAMILIES CONCERNED ABOUT AIDS

CONCERNED PARENTS SPOT

Wouldn't it be nice if the world were perfect, and you never had to worry about your teenager?

But the world isn't perfect, and you can't watch over teenagers every minute....

And many terrific kids like yours are now being infected by AIDS.

Today there are 40,000 teens in New York City infected with the virus which causes AIDS...and most don't even know it.

What can you do about it?

The New York City Board of Education will consider a comprehensive program of AIDS counseling and education for teenagers, a prevention program where parents and teenagers work together...

A program that would also include condoms.

Unfortunately, this program won't pass without you.

Please, call the Board of Education and tell them you support the program.

The number is 718-935-3300.

Tell them it's your child's life, and nothing matters more.

Brought to you by Families Concerned About AIDS.

Call 718-935-3300.

Families Concerned About AIDS. Concerned Parents Spot. New York, NY: Families Concerned About AIDS, 1991. Used with permission.

FCAA hopes the radio spots will bring a sense of urgency and need for Fernandez's AIDS Education Plan to be put into effect and will move members of the New York City Board of Education to vote on the initiative promptly. "It is vital that young people learn as quickly and as easily as possible the consequences of their behavior and the precautions that are available and must be taken," said Mary Ida Gardner, Executive Director of The Upper Manhattan Task Force on AIDS. Eighty percent of New York teenagers are estimated to be sexually active by their 19th birthday. New York City, with only 3% of the nation's 13-to-21 year olds, already accounts for 20% of the nation's reported AIDS cases in that age group.

For more information or a copy of the radio spots, please call David Eng at (212) 807-6664.

###

CPO RESPONDS TO NEGATIVE ARTICLES ON SCHOOL-BASED HEALTH CENTERS

Since the results of CPO's evaluation of six school-based clinics, there has been a steady stream of negative articles from opponents of SBCs (anti-abortion) calling for the demise of SBCs based on the lack of evidence that SBCs reduce teen pregnancy. Much of what is written in these articles distorts the truth by leaving out information that does not support their views and by drawing conclusions which the data do not support. They continue to characterize SBCs as "birth control programs" which promote value-free promiscuity among the students attending schools in which they are located. Nothing could be further from the truth. Specifically, the following points should be noted:

(1) These articles fail to note that only a small percentage of SBCs actually provide contraceptives on-site. The lack of access as well as the message of ambivalence this sends to sexually active students necessarily weakens the potential of the SBC's reproductive health services to prevent pregnancies. Where contraceptives are not available in the clinic, students are less likely to come to the clinic for reproductive health counseling. Opportunities for health providers to discuss responsible sexual decision making -- including abstinence as a possible option -- with students are undoubtedly lost.

(2) These articles also fail to mention the evidence that the provision of contraceptives on site does not result in an increase in the percentages of students who are sexually experienced, does not result in a decrease in the mean age at first intercourse among sexually experienced students, nor does it result in an increase in the frequency with which students engage in intercourse. In fact, in some sites where this has been assessed, there was evidence that there was less sexual activity among students attending the clinic schools compared to the non-clinic schools.

Related to this is another important finding that is missing from these negative articles -- that the percentages of sexually experienced students in many schools is very high -- sometimes over 85%, regardless of whether an SBC is present or not. Sexually active students need access to reproductive health care. Comprehensive health care must address reproductive health of sexually active students.

(3) Many of the articles in question confuse "correlation" with "causation". Many cite examples of clinic schools with high pregnancy rates compared to schools without clinics with lower pregnancy rates and draw the conclusion that clinics promote promiscuity and therefore promote increases in pregnancy rates. The more likely explanation is that clinics are started in school in communities with high pregnancy rates as one way of addressing the problem. In CPO's study where comparison schools were matched on the basis of geographic, demographic and socio-economic characteristics, there were no differences between clinic and comparison schools in pregnancy rates.

(4) The fundamental error in these articles is their assumption that SBCs are primarily teen pregnancy prevention programs (or "birth control programs"), and they are not. While the initial motivation for starting some clinics was the expectation that SBC programs would be able to address teen pregnancy as part of comprehensive medical care, family planning services are not the primary services offered. Even where contraceptives are available on site, family planning visits comprise only about a quarter of the total visits.

The primary purpose of school-based clinics is to provide health care to a typically underserved population in an easily accessible location. To suggest that policymakers evaluate school-based clinics solely on the basis of school-wide pregnancy rates is ludicrous. Adolescent pregnancy is a complex problem with many interrelated underlying causes. CPO's evaluation of SBCs demonstrated that it is unrealistic to expect this intervention by itself to resolve the problem. SBCs, however, can serve as one important component of the multiple interventions needed to make a difference.

(5) On the basis of its evaluation study, CPO was able to provide a set of recommendations which if implemented can improve the SBC's ability to address the issue of adolescent pregnancy more effectively. Some of these recommendations include:

- Giving a high priority to pregnancy prevention and AIDS
- Conducting more outreach into the school
- Identifying and targeting students engaged in sexual activity
- Making contraceptives available throughout the clinic
- Implementing effective follow-up procedures
- Emphasizing condoms and male responsibility

CHAPTER FOUR

DESIGNING A PROGRAM

The features of each condom availability program are determined by a combination of state law, school board policy, administrative guidelines and local school decisions on implementation. These factors combine differently in the decision-making process in each district. For instance, decisions seen as policy in one school district may be viewed as part of an implementation plan in another. Some school boards may adopt an explicit policy that makes condoms available through school nurses; others may simply approve condom availability as part of their state mandated HIV/AIDS education program, and leave design issues to the superintendent or local school principal.

In this guide, the term "program design" refers to the composite of policy, goals and procedures that characterize a specific condom availability program. Regardless of who decides, and when decisions are made, the basic design questions concerning who, what, when, where and how must be addressed.

This chapter describes options for answering basic design questions, and discusses implementation at the local level. The information will be useful to advocates, policymakers, school administrators and local school officials in evaluating program options and deciding the best approach for their community. In addition, direct contact with administrators or program directors in schools that have implemented condom availability is strongly recommended.

I. THE DESIGN TEAM

Teams of school officials, staff, students and outside experts participate in the process of designing and developing a plan to implement the program. Such teams may be appointed by the school board, the superintendent, the principal or the health commissioner.

A. Membership

Unlike coalitions (See "Organizing a Coalition for Advocacy," Chapter 3), membership on a design team is limited, and depends largely on the task assigned. Team members must:

- have direct knowledge of the school system or local school
- be able to make judgements about whether objectives can be effectively implemented at the local school level
- be knowledgeable about adolescent culture and sexual risk-taking behavior
- be committed to the goal of the condom availability program.

Individuals who have some responsibility for implementing the plan should also be included on the team. Principals should either be on the team or consulted by it. School administrative and teaching staff (especially those currently involved in the provision of health education or services, including teachers, counselors and school nurses) should also be included.

A representative of the health department who specializes in adolescent health, pregnancy prevention or HIV can provide a valuable liaison with the health department, and can facilitate future coordination on the program. It may be strategically important to consult or include representatives of local unions — such as teachers, administrators or health aides — whose support for the program will be needed. If the policy requires significant collaboration with other community agencies, these should be represented as well.

Including parents and students on the design team is one way to ensure their essential input. If possible, the team should be representative of the target student population in gender, ethnicity and race to ensure sensitivity to cultural issues. Individuals from community-based organizations can be brought in to help with specific components of the plan. They might include AIDS educators, family planning providers, peer program coordinators or substance abuse counselors.

The design team may be a core group of six to 10 that expands to 25 or 30 depending on the subject.

II. DESIGNING THE PROGRAM

After the team is in place, program design can begin. A discussion of program goals and objectives, as well as methods and examples of program design, follows.

A. Setting Goals and Objectives

From the start, the design team must have clear goals and objectives for their process and for the program.

A **goal** represents a long-term planned accomplishment for a program. The design team might have as its primary goal "to develop a plan for making condoms available to students engaging in sexual intercourse as one component of a comprehensive HIV prevention education program." A broader and more long-term goal might be "to decrease the number of sexually active students engaging in unprotected sexual intercourse." The goals for the program and the design team may have been chosen by the superintendent, health department official, principal or school board, or it may be left to the design team to determine its goals.

Objectives are short-term, specific and measurable results or effects which a program or project is to accomplish. Determining objectives for both the program and the design team is a very important part of the early planning process. In developing objectives, it is useful to consider a timeline and to plot anticipated milestones along it. Examples of objectives for a design team are:

- Complete needs assessment survey by February 3, 1994.
- Distribute Implementation Guidelines to every high school in the city by June 12, 1994.

Examples of objectives for the program are:

- Provide six hours of classroom instruction in HIV/AIDS prevention and sexuality education to students in grades nine through 12.
- Make condoms available five days a week, excluding school holidays and teacher work days.
- Distribute information about condom availability to students and parents at the beginning of the school year.

The program will be measured or evaluated against its goals and objectives. Consider methods and criteria for evaluating the program in the earliest stages of program design. Decisions about what to measure affect program design choices, as they clarify the desired impact and allow the design team to identify factors that might affect achieving the goal. Evaluation strategies are important for responding to skeptics and opponents and for demonstrating the value of the condom availability program.

Systems should be established early in the process to gather data for measuring the program's success. Sometimes data collection methods present barriers to teens if they are too cumbersome or time-consuming. In that case, alternative ways must be found to evaluate the program.

(See Chapter 5 for a discussion of evaluation strategies and suggestions for setting program goals and objectives that are realistic and measurable. See Attachment IV.A.1 for a summary of the Washington, D.C., goals and implementation plan.)

B. Selecting Design Features

Ultimately, the program must be tailored to meet the district's or school's own unique balance of needs, resources and limits. Applying the following criteria to program design features will help ensure effectiveness:

- Does it meet policy and legal requirements (e.g., specified staffing, parental involvement, etc.)?
- Is it goal-driven (i.e., will it meet the needs of teens, maximize their access to condoms, improve their knowledge of and attitudes toward condom use, reduce risk-taking behavior – whatever goals have been determined for the program)?
- Does it minimize costs and maximize use of existing resources (human, financial and material)?
- Is it easy to administer?
- Can it be evaluated?

To assess whether a particular component meets these criteria, a team needs information about the students and the local school. Some information, such as whether there is a school nurse, may be readily available to team members. Other information may only be available through additional research on the school environment. Focus groups with teens, faculty or staff will almost always yield information useful in assessing the choices. For instance, if teens report that cost is a significant barrier to consistent condom use, then, unless a reduced price can be negotiated, installing vending machines would not be effective in increasing both condom access and use.

C. Program Components: Who, What, When, Where and How

A number of different models have emerged for school condom availability programs, largely the result of policy choices by school boards and health agencies. This section discusses the different components of condom availability programs. Chapters 7 and 8 present in-depth case studies of several programs.

Who will make the condoms available?

School Staff. Staff currently involved in programs include principals, nurses, teachers, guidance counselors, coaches, school-based health center staff and other school staff. In some schools, such as those in New York City and Adams County, Colorado, staff participation is voluntary. In other programs, school nurses and others have been specially designated to make condoms available.

Students. Peer counselors in many schools make condoms available to their friends informally, and there may be appropriate and effective ways to involve them in the program. Los Angeles has incorporated peer counseling and education groups into their program: peers help staff the school-based health center's condom availability program.

Outside Staff. Districts such as Philadelphia that, as a matter of school board policy, do not allow school staff to provide condoms have invited staff from outside agencies into the school. These may be staff in the local health department, family planning clinic, HIV/AIDS prevention groups or medical and social work students. In other school systems, such as Washington, D.C., and Boston, the school nurses who make condoms available are employed by the health department rather than the school. While this staffing pattern is less expensive and complicated for the school, it can be quite costly to the outside agencies.

Non-Interactive Methods. Some schools place baskets of condoms in health centers, the nurse's office or bathrooms. Because this method is less threatening to young people than a personal encounter, teens may use it more readily. This is also one of the least expensive options, since condoms are relatively inexpensive. Another non-interactive option is to install vending machines in bathrooms and locker rooms. Vending machines represent no cost to the school, since vendors install, maintain and stock the machines. Vending machines may not, however, reduce the cost to the student. Non-interactive methods may also reduce the likelihood that students will seek counseling and referrals for health or social services.

Who will be eligible to receive condoms?

High School and/or Middle School Students. Most programs are limited to the high school grades. Due to especially high-risk factors among preteens, several school districts, including Washington, D.C., have established condom availability programs in some middle schools. Special procedures or requirements not necessary for older students, such as mandatory counseling, are sometimes adopted for students in the lower grades.

Hard to Reach Students. Strategies should be adopted to make the program accessible to students that can be hard to reach with prevention messages, including foreign language and learning disabled students.

Consent requirements. Some school districts, including New York, Washington, D.C., and some school-based health centers, permit all students to receive condoms upon request. In some school-based health centers, condoms – like other services – are only available to students who have been enrolled in the health center by their parents through a special consent form. Other programs, including Philadelphia, permit parents to opt their teenagers out of eligibility. Supporters of parental opt-out provisions claim:

- It may be necessary politically to secure approval for the program.
- Less than 5 percent of parents actually opt their teens out of the program, so very few are being denied access to condoms.
- It helps parents to enforce their own moral values within the family.

Opponents of opt-out provisions argue:

- It may deter teens from asking for condoms.
- Some teens at risk of pregnancy or HIV may not be permitted access to condoms.
- The logistics of maintaining records are complicated and costly.
- It is difficult to enforce.

(See "Active and Passive Parental Consent" in Section V.5 for a discussion of advantages and disadvantages of parental involvement options, and Chapter 8 for information on consent procedures in school-based health centers.)

What will be made available to students?

Condoms. Schools may limit the number of condoms dispensed during a single encounter, or they may allow students to take as many as they want. Typically, schools provide two to 10 condoms at each visit. One program allows teens to take up to 50 condoms, with the expectation that they will be passed to other teens at risk. (For information on what to look for when purchasing condoms, see "Condom Purchasing Information and Options" in Section VI.)

Instructions or Other Written Materials . Schools should provide separate written instructions for proper condom use developed by the manufacturer or written specifically for teens using their program. In most cities, these instructions are available in a variety of languages to meet the needs of diverse student bodies. The design team must decide if other educational materials— brochures about AIDS, other STDs, pregnancy prevention, etc. — will be provided. These materials may need to be written and published or purchased.

Education. Every encounter between a student seeking condoms and staff of the program is an opportunity to teach. Many issues related to sexuality and risk-taking behavior may be raised by the student, and staff should be trained to respond. On the other hand, any mandated educational component must be carefully considered, since teens are likely to be "turned off" by a "lecture" or admonitions about abstinence. Schools may decide to provide literature, demonstrate the use of a condom and/or discuss the relative risks of protected and unprotected intercourse. (See "Student Education and Counseling Components" in Section IV.)

Counseling and Referral. Counseling may be required or available upon request. In some sites, counseling is required only at the first visit, but other districts require it every time condoms are requested. Counseling may be provided by staff of the condom availability program, or by other sources as well. If counseling and condom availability staff are different, some means of indicating that a teen has received required counseling (such as a token or card) will be necessary. (See "Counseling and Referral" in Section IV.B.)

Other. Through interviews during their internal needs assessment, the design team in Philadelphia discovered that students felt uncomfortable with a "condom room" where everyone would immediately know the purpose of their visit. Students suggested that other items attractive to teens — tickets to sporting events, information on other health issues and community resources and events, etc. — also be made available to help safeguard student confidentiality.

When will the program operate?

Throughout the School Day. Making condoms available through the entire school day maximizes student access. Programs using vending machines or baskets accomplish this goal. Programs that require counseling or interaction with an adult may schedule continuous staffing throughout the day, provided adequate staff participates in the program.

Specific Hours During the School Day. Programs that require counseling or other interaction may not be able to staff them the entire day and may have to limit availability to certain times of the day. Some programs mandate availability for specific periods or hours each day or week during which almost all teens are free: before school, after school and/or lunch time. Others mandate a minimum number of periods or hours and allow the local school and staff to set the schedule. In this case, a student needs assessment is useful to establish a

schedule that will maximize access. The plan must include adequate publicity so that all students are aware of the schedule.

After School Hours, Weekends and Holidays. Some schools have enlisted health departments, clinics, pharmacies and community-based organizations to ensure students' access to free condoms even when the school is not open.

Where will condoms be made available?

School-Based Health Centers. Schools with existing clinics or health centers often use this site for condom availability. When health center operating hours are limited, however, this may not be adequate to ensure easy student access. Furthermore, use of school-based health centers is not an option for most schools, as relatively few have health centers on site. (See Chapter 8 for an examination of condom availability in school-based health centers.)

Designated Spaces. Some schools create a separate space for the program. These drop-in centers or health resource rooms may be necessary if the program incorporates outside staff or other new student services such as health counseling and referral. Special care needs to be taken to ensure that the location and setting of any services provide confidentiality for the student. When a condom availability program is staffed by school-based health center personnel, school nurses or guidance counselors, there is usually no need for a separate, designated space since these professionals already provide confidential services. If educational materials or other services are to be provided, space needs to be allotted for them as well.

Staff-Based Programs. In Adams County, Colorado, rather than having a designated *place* for students to go, volunteer faculty advisors carry condoms and materials with them. In New York City high schools, condoms may be available at several different locations, such as classrooms and guidance counselors' offices. The school should publicize the condom availability schedule and location adequately or student access will be limited.

III. STAFFING AND TRAINING

Staffing and training may be the most important factors in a program's effectiveness. Select or recruit staff with a positive approach to teens and the ability to gain their trust. Careful selection and appropriate training of staff can improve sexually active teens' willingness to ask for condoms and increase the likelihood that they will use them.

A. Selecting Staff

To overcome barriers to access and to promote condom use, programs will need both male and female staff who are:

- approachable and trusted by teens
- able to listen
- able to maintain confidentiality
- comfortable talking about issues related to sexuality and supportive of condom availability.

The importance of the type of staff working with adolescents is evident in the experience of one school-based health center, where the number of student visits quadrupled after a new medical director was hired.

The number of staff needed for a program will vary greatly, depending on:

- size of the student body
- number of students likely to use the program (percentage of students who engage in sexual intercourse)
- program requirements for counseling and education (which affect the time involved in each encounter)
- whether the program uses internally designated or mandated staff or outside staff
- when and for how long the program operates each day.

Using School Staff. Since time and salaries are already budgeted, the most cost-effective approach to staffing will use existing school staff in the condom availability program. Sometimes school board policy or implementation guidelines designate existing school staff be involved. Usually this is the school nurse, but may also include guidance counselors, principals, athletic staff, health educators or others. One benefit of assigning staff is that it eliminates having to recruit and screen volunteers. Designated staff usually already have certain skills or information needed in the program. Assigned staffing also may make other logistical decisions, such as location and scheduling, easier.

While assigned staffing may be efficient for managing the program, there are also some disadvantages. Not every school will have a nurse, or there may be too few individuals in these specific roles to meet the needs of the program. For example, the ratio is fewer than one nurse for every seven high schools in New York City; they cannot provide effective intervention including counseling and referral, in addition to a full case load and schedule.

Furthermore, not all staff support condom availability or are comfortable with their assigned role. Due to personality or their role as an authority figure, certain individuals may not be considered approachable by teens. Special training will be required to address these problems.

To avoid the potential problems associated with assigned staffing, some schools have chosen to staff the program with faculty and staff volunteers. Using volunteers often increases the number and diversity of staff involved in the program, increasing the likelihood that students will know and feel comfortable with at least one staff member. Using volunteers also ensures that individuals who support the goals of the program are responsible for implementing it. However, working with volunteer staff requires special strategies for recruitment and training.

One district is considering the use of focus groups and interviews to obtain student input and nominations for condom availability staff. The team would then approach the nominated individuals about their willingness to participate in the program.

If the school has volunteers staffing the condom availability program, the design team will need to answer the following questions:

- What is the job description?
- How many staff people and volunteers will be needed?
- What qualifications are most important?
- What is the recruitment plan?
- What staff training and oversight will be needed?
- What additional confidentiality safeguards may be needed from staff?

Using Outside Staff. Some condom availability policies prohibit school employees from providing condoms to students, but instead allow local health agencies to staff the program in the school. The cooperating health agency might be a local hospital, teaching hospital, family planning clinic or health department.

An agreement between the school and local agencies should outline the responsibilities of each party including: providing condoms and other materials, handling administrative tasks such as those required by parental opt-out policies, collecting data, program oversight, etc.

The agreement should also clearly establish how staff-related costs will be allocated among collaborating groups. These costs can be considerable, since a program using outside staff will require the agency to add staff or deploy its staff or volunteers in a new way. While the agency may place a high value on the condom availability program, it may not have sufficient resources to cover costs and provide staff alone.

Bringing non-school staff into the school building will usually require the school to allocate space for the program, but might relieve the school of direct responsibility for training program staff and administering the program.

Using Peer Education Groups. Peer pressure and perceived peer norms are reported by teens to be important factors in encouraging condom use. In some cities, HIV-education peer groups have been instrumental in the adoption of condom availability policies. Many peer educators give condoms informally to their friends and classmates. These groups may be involved appropriately in formal condom availability programs as well.

Peer educators should not be the only source of condom availability, however, since concerns about confidentiality may make it difficult for teens to approach their friends. Nevertheless, some teens may feel more comfortable discussing the issues with another teen than with an adult authority figure.

Peer education groups require adult supervision, support and training.

Other Staffing Needs. In addition to interacting with students in the condom availability program, there are other functions that must be served as the program is implemented. Individuals or a group should be designated to perform tasks associated with:

- evaluation
- oversight, support and administration
- public relations for the program.

B. Training

Given the complexity of the subject, the range of misinformation about HIV and AIDS and public sensitivities surrounding adolescent sexuality, appropriate training must be provided to staff, volunteers, administrators and parents. "Training" is a specific kind of learning experience that involves exploring attitudes, gaining knowledge, developing and practicing skills. Because new information or rumors about HIV/AIDS are available every day, regular updates or "refresher courses" for the school community are also advised.

Who Needs Training? The following are potential participants in a condom availability training:

- the staff who will counsel students and provide condoms
- school principal and vice principal
- school board members
- parents
- students
- community leaders, including clergy
- school-based health center staff and/or the school nurse
- other school administrators, interested teachers and staff
- other school community members.

There are different training goals for each of these groups. The training may be a very hands-on, skills-oriented session for those individuals who will counsel students and provide condoms, or it may provide information to members of the school community whose support and understanding is needed. The training should always be designed with the target audience in mind.

Training might be offered in several stages. The "orientation" training can be open to representatives of many different constituencies. Follow-up, or more advanced, training can then be offered to the personnel who will actually implement the program. Time, money and trainer availability will affect decisions about how many people are trained and how many trainings are offered. At the very least, it is imperative that those who actually implement the program and interact with students receive training.

Who Can Provide The Training? Experienced HIV, health or sexuality trainers with knowledge of or direct experience with youth are ideal. They bring a combination of good training skills, comfort with sensitive issues and knowledge of young people. It will be necessary to have a "resource" person from the administration (school or district) available during the training sessions to answer policy-related questions as they arise.

There may be staff in the school or at the district level who are appropriate for leading the training. Many outside agencies and organizations are good places to look for trainers. Planned Parenthood, local AIDS service agencies or other health care organizations, including the local health department or the state education agency's AIDS education coordinator, are potential sources for trainers. Many large communities have private health trainers or consultants who might be suitable as well. The Center for Population Options (CPO) offers training and technical assistance support to school districts by contract.

The costs of training will vary with the number of participants, amount of materials, charge for space and trainers' fees. Some school districts have had success at soliciting *pro bono* training help from local agencies for the first year of implementation; if funds are limited, explore that option. If the trainers come from outside the school, it is essential that they work closely with the appropriate administrators to design an effective training.

It is very helpful to have two people lead the training; while one is leading the discussion or activity, the other can watch the clock, write on newsprint, monitor the group, etc. One trainer might have expertise in HIV/AIDS and the other in working with adolescents; they should complement each other's skills.

What Should Be Included in the Training? Although the content of a specific training depends on the goals and the audience, a comprehensive training should give participants the opportunity to:

- Increase understanding about HIV/AIDS-related issues including the modes of HIV transmission, testing, condom efficacy and risk-reduction activities.
- Learn about adolescent sexuality within the context of adolescent development and behavior change.
- Become familiar with the condom availability program's policies and procedures.
- Explore personal attitudes and concerns about their roles in the condom availability program.
- Practice talking about and demonstrating proper condom use.
- Explore effective condom use negotiation techniques.
- Consider and practice effective communication and counseling techniques.
- Identify steps to take to become competent in working with members of various racial, ethnic, gender and sexual orientation groups.
- Reflect upon the myriad pressures that have an impact on adolescents today.

Including a range of topics related to HIV, sexuality and adolescence in the training will give participants an opportunity to expand their knowledge base and comfort level, while simultaneously reinforcing the concept that HIV and pregnancy prevention are linked to multiple issues.

When planning a training, it is wrong to assume that everyone is familiar with the facts. Almost every group is composed of individuals who may be extremely knowledgeable about HIV and others who are very ill-informed. It is essential to include "basic" HIV/AIDS information in the training and to give ample time for participants to ask questions, preferably in small groups.

To be committed and enthusiastic, the condom availability staff needs the opportunity to "own" the program. An informative, interesting, enjoyable, hands-on training – rather than a lecture – will foster such ownership.

(See Attachment IV.F, "Components of a Comprehensive Condom Availability Training.")

What Might The Training Agenda Look Like? The number of days needed for training depends on the design of the program and the size of the school or district. A comprehensive training, such as that recommended here for the staff who implement the program, will require a minimum of two days. If logistics prevent all relevant staff from gathering two days in a row, consider offering the same training several times, offering it four mornings in a row or some other workable variation.

There is no boilerplate for training that is useful or appropriate for every setting. Each school or school district will have a unique policy framework with which to work. For example, workers in a program that requires repeated one-on-one counseling with students will need different training than workers who will do much less counseling. The training must be tailored to best fit the needs of the audience.

A summary of the HIV/AIDS education training design of the New York City Public Schools is provided in Attachment IV.B. Copies of the training manual are available upon request from the HIV/AIDS Technical Assistance Project, which is listed in Chapter 9.

What Kind of Data Should Be Collected To Evaluate the Training? Evaluate the training component of the program to improve it for subsequent use and to identify further training needs. Attachment IV.C provides a sample evaluation form that can be modified for use in any program.

It might be helpful for planning future trainings to follow up with participants several months later, asking them questions such as: "What was the most useful information you gained during the training?" and "What do you wish you had learned?"

IV. STUDENT EDUCATION AND COUNSELING COMPONENTS

In order to protect themselves against pregnancy, HIV and other sexually transmitted diseases (STDs), adolescents must know the facts about sexuality and disease prevention. Students also need adult support when confronting these issues personally. Condom availability staff are in a unique position to identify students who need help and to facilitate their access to it. The design team should try to create a program that offers students the information and support they need without creating what teens will view as obstacles to condom access.

A. Education

Education about HIV and other STDs may already be in place in the school or school system. In many schools, however, the HIV/AIDS education requirement is limited to a few hours in health class. The discussion of condom availability provides an excellent opportunity to evaluate current HIV education practices and to improve them.

Condom availability staff can facilitate classes, assemblies and small group sessions to present HIV prevention materials outside of the existing curriculum. This is helpful in two ways:

- Students get to know staff and begin to identify the team members from whom they can access condoms. Moreover, students get a chance to evaluate the openness and acceptance they can expect from the condom availability staff.
- Facilitating educational sessions helps the team reinforce the information provided in the curriculum. If the school does not have a curriculum, there are excellent models from which to choose and organizations that can help in the selection.

Parents and school staff also need basic HIV/AIDS information. Providing teacher in-services and parent workshops reinforces the importance of the program, educates adults about HIV facts and fallacies and facilitates communication between students and their teachers and parents.

B. Counseling and Referral

In some programs, students are required to receive individual counseling every time they want condoms. Some programs require students to demonstrate proper condom use on a penis facsimile either after initial counseling or whenever they come for condoms. Others make counseling available but not mandatory.

Many have been surprised by the information and support young people seek from the program staff. Some students want to acquire a condom with the minimum of fuss and bother. Others need someone to talk to about topics that could include sexual decision-making, the proper technique of using a condom or negotiating condom use with a partner.

Adolescents may also need someone to talk to about seemingly unrelated issues. Topics of sexual abuse, drug and alcohol use, failing grades or problems at home may surface in the counseling session. The team must consider whether to provide referrals to outside agencies or to existing resources within the school. In Philadelphia, where the program is managed by health agencies, referrals for health and social services are considered one of the most important services offered by the program.

Each school's design team must decide what referrals will be made. A list of approved agencies or individuals may be compiled if one is not already available in the community or through the school guidance office. The team may need to establish an agreement with a local clinic or hospital to refer students in need of medical and mental health services.

As indicated above, the team may choose to provide counseling to students each time they seek condoms or only the first time they access the program. In either case, the counseling session should take place in a quiet area where confidentiality is maintained. The duration of the session should be dictated by the student's questions and concerns. Staff should always reinforce that they are pleased the student has acted in a responsible manner by accessing the program. Moreover, the counselor may wish to explain that he or she is available to discuss any concerns the student may have about relationships, sex or using protection. (See Attachment IV.G, "Guidelines for Individual Counseling.")

For help in learning counseling skills, turn to local resources. See the previous section on training for some possibilities. Other resources for training include the clinical services staff of local health care, social service and family planning organizations. The human services departments of the local government can provide information on obtaining counseling training.

V. VALUE OF PARENTAL INVOLVEMENT

One of the most sensitive areas in designing a program is how to involve parents. These decisions are, to a certain extent, governed by state and federal law. (For further discussion of legal requirements and implications, see Chapter 6.)

The extent of parental involvement depends on the goals of the program, available funds and staff time. A program that seeks to reduce adolescent risk-taking behavior is likely to be more effective with the active support and participation of parents. Schools will be more successful if they find creative ways to engage parents in reinforcing the lessons taught in school.

On the other hand, a program whose primary goal is more limited (i.e., to reduce physical barriers to access by making condoms available upon request or through vending machines), may not need the same aggressive strategies for engaging parents. In every instance, however, program designers should reinforce parents' responsibility as primary sexuality educators for their children.

The question of the parental role is usually debated in terms of active or passive parental consent requirements, but there are also other ways to satisfy the need for parents to be informed and involved. The following section briefly describes strategies for parental involvement and some of the benefits and drawbacks of each.

A. Parent Education and Input

Schools have found that parents' anxieties about condom availability programs are eased when they learn condoms are provided as part of a comprehensive program of prevention that seeks to prepare teens for adult responsibilities and aims to reduce the risk of serious negative consequences for the choices teens make. Parents also find it reassuring that the program provides condoms to students who are already engaging in sexual intercourse *and* affirms students who remain abstinent.

Parents and other members of the school community also need accurate information about HIV and AIDS, not only to reinforce for their children lessons learned at school, but also for themselves. Students often express to AIDS educators a deep concern for their parents, who may be less informed than they and are taking unnecessary risks.

Effective communication is more than one way; it should provide school officials with feedback about how parents perceive the program. By assessing parental support, schools may be able to address concerns before they erupt into conflict or endanger the program.

Channels of communication can be established through the Parent Teacher Student Association (PTSA) or other parent groups. Guaranteeing parental representation on advisory committees will satisfy most parents that their concerns are heard and addressed.

Parent Education. Parent education can be conducted through:

- mailings to the parents at home, annually or more frequently
- presentations to PTSA and other parent groups
- materials sent home with students
- adult education classes on HIV/AIDS prevention
- new student/parent orientations
- print and broadcast media coverage.

Parent Input. Parent input can be obtained through:

- parental representation on the design team
- parental participation on an advisory board
- talk-back sessions after presentations to community groups
- parent focus groups
- telephone polls
- questionnaires sent separately or with regular mailings.

Materials for Parents. Materials should be made available to parents that include information on:

- the risks to teens of pregnancy, HIV/AIDS and other STDs, including national and local data
- ways the school is addressing these concerns, including health and skills-building education
- how the condom availability program works
- how the school supports decisions to abstain from sexual intercourse.

Educating parents is most important in the earliest stages of the program, when they want to know exactly how it will work. Briefings for parent groups are a way of allaying fears and keeping parents informed. Over time, as the majority of parents become familiar with the goals and strategies of the program, the frequency of briefings, presentations and talk-back sessions may be reduced. Parents of new students should always receive information about the program along with other materials.

B. Active and Passive Parental Consent

Because privacy and confidentiality are so important to teens, most people who work directly with young people believe that parental consent or "opt-out" provisions deter teens from asking for condoms. This belief is supported by informal surveys of teens who, when asked, overwhelmingly oppose both consent and opt-out requirements even if they have good relationships with their parents. No hard data exist, however, on the deterrent effect of parental opt-out mechanisms.

Decisions about parental consent will sometimes be directly related to the method chosen to make condoms available. For example, parental consent is not realistically enforceable when condoms are available through vending machines.

The source of funds for the program may also influence the adoption of parental consent or opt-out provisions. Title X, the federal family planning program, prohibits making family planning services for minors conditional on parental consent and/or notification. Therefore, a school-based health center or health department using Title X federal funds may not impose a parental consent or opt-out requirement for contraceptives. Conversely, a program that requires active parental consent or opt-out may not use Title X or similarly regulated state funds.

Active Consent. Active consent permits only those students whose parents have signed a permission form to receive condoms. Active consent is rarely required, except in the few school-based health centers that list condoms as one of the services for which parents must provide explicit consent when enrolling their adolescent in the center. (See Chapter 6 for more information on legal issues.)

Consent forms are generally distributed to parents at the beginning of the year; only those students whose parents sign and return the forms would have access to condoms. Unfortunately, in addition to teenagers whose parents do not wish them to have condoms, teens would also be excluded if their parents forgot, misplaced, could not read or simply failed to read the materials. This type of consent might also be challenged on the basis of an adolescent's right to privacy and access to contraceptive services.

Passive Consent. Passive consent, or "parental opt-out," makes condoms available to all students *except* those whose parents deny permission in writing. Most of the problems associated with active consent apply to opt-out provisions, including the need to maintain confidential records and to enforce the provision. However, teens cannot be unintentionally opted out of the program as they may frequently be with an active consent requirement.

In programs that have adopted a passive consent, approximately three to five percent of students have been opted-out by their parents. Nevertheless, *all* students are required to identify themselves before receiving condoms, to ensure they have not been opted out. Identifying themselves by name or by showing proof of identity may present a significant barrier to teens who wish to remain anonymous, both to peers and to school staff. Some schools have found that problems of enforcement cannot be overcome without procedures so intrusive and cumbersome that they would undermine the program's effectiveness.

The issue of parental consent is often decided by school boards or health departments on the basis of what they believe is politically possible, rather than through determination of the policy that best achieves the goal of reducing the risks to teens.

Proponents of opt-out procedures for condom availability programs feel very strongly about the issue. Advantages and disadvantages of different parental involvement models are presented in the chart on the following page.

If a school chooses to require parental consent or adopt an opt-out procedure, it must conduct the following administrative tasks:

- Design a response form. (See Attachments IV.D.1-3 for a variety of sample consent and opt-out forms.)
- Develop a data base, to record responses from forms, capable of generating up-to-date lists of students eligible and/or ineligible for condoms. Steps must be taken to maintain the confidentiality of information in the database.
- Adopt protocols that address how students will be identified to staff (whether they need to produce some form of identification or whether it is sufficient for them just to give their name) and how confidentiality will be protected.
- Decide how the list will be managed, including how often it will be updated or reissued, whether there will be a deadline for the return of forms, what will be done with forms turned in after the deadline, how to handle changes in the list when individuals move, graduate or drop out.
- Circulate lists to condom availability volunteers and staff, accompanied by instructions on safeguarding confidentiality.
- Establish criteria and methods of evaluating effectiveness and impact of consent or opt-out procedures. Revise procedures as necessary.

BENEFITS AND DRAWBACKS OF STUDENT REQUEST, PARENTAL CONSENT AND OPT-OUT FOR CONDOM AVAILABILITY PROGRAMS

	Student Request	*Parental Consent*	*Parental Opt-Out*
Benefits	Maintains confidentiality Reduces embarrassment No teens denied access Maximizes impact of program Minimizes record-keeping Does not violate adolescents' rights to contraceptives and STD treatment	Reinforces parental authority Reduces parent opposition	Reinforces parental authority Most teens allowed access Reduces parent opposition
Drawbacks	Politically difficult to achieve	Minimizes access, may deter all teens Significant cost to implement Loss of confidentiality: student must give name Administrative problems: record keeping, student identification Enforcement obligations and difficulties May violate teens' right to contraceptives and STD treatment Minimizes impact of program and behavior	Reduces access and may deter all teens Significant cost to implement Loss of confidentiality: student must give name Administrative problems: record keeping, student identification (less onerous than with consent) Enforcement obligations and difficulties May violate teens' right to contraceptives and STD treatment

VI. CONDOM PURCHASING INFORMATION AND OPTIONS

Arrangements are usually made at the district level for the purchase or donation of latex condoms from manufacturers or the local or state health department. Interacting with these agencies may be a new experience for school staff unless they are associated with a school-based health center or outside health agency that has already established a source of condoms for distribution to the public. (See Attachment IV.E, "Condoms Available Through U.S. Distributors.")

Some of the barriers to adolescent condom use are directly related to teens' perceptions about condoms. Therefore, the design team needs to know what factors are important to teens when considering brands and styles of latex condoms. Ideally, the program should offer a variety of styles and sizes of condoms. By providing choices, the program helps teens discover what works best for them and can further reduce resistance to condom use.

Most U.S. distributors of latex condoms adhere to voluntary standards developed by the American Society for Testing and Materials that govern the size, elasticity, thickness, strength and leakage of condoms. These standards have been accepted by the Food and Drug Administration (FDA), and are the basis for the statement that properly used latex condoms are highly effective in preventing sexually transmitted diseases, including HIV, and pregnancy.

Surface-strength and leakage tests are part of these standards. Similar tests are not required in the manufacture of latex surgical gloves; studies conducted on the effectiveness of surgical gloves in preventing transmission of HIV are not relevant to latex condoms.

Latex condoms do not allow the passage of water. Since a water molecule is five times smaller than HIV, latex condoms which are impervious to water are also resistant to HIV transmission. At least one manufacturer tests each condom electronically for holes before packaging it.

A. Choosing Which Condoms to Order

Condoms cannot eliminate all risk of pregnancy or sexually transmitted diseases. Nevertheless, proper and consistent use of latex condoms greatly reduces these risks. Natural skin condoms may be effective in preventing pregnancy but do not protect against transmission of disease. Some studies quoted by opponents of condom availability programs to suggest that latex condoms are ineffective for preventing the spread of HIV and other STDs are actually studies of natural skin condoms. While these condoms can be used in tandem with a latex condom by individuals who are allergic to latex, they should not be used alone. Novelty condoms, such as french ticklers, should also be avoided.

Standard latex condoms are between 0.03 and 0.09 millimeters thick. Greater thickness does not always mean that the condom is more resistant to breakage. The risk of breakage very much depends on user behavior. Some manufacturers market an extra strength condom for people who experience breakage with standard condoms.

A receptacle tip is an important feature that helps reduce slippage after ejaculation by providing space for the ejaculate. Some condoms offer additional features, such as an adhesive around the open end, to help prevent accidental slippage.

Some condoms are lubricated with nonoxynol-9, a spermicide that provides added protection against pregnancy. In laboratory tests, nonoxynol-9 has killed HIV, but there is no clinical evidence yet that nonoxynol-9 kills HIV in the human body. Therefore, it is *possible* that the use of nonoxynol-9 can increase protection against HIV, but it is not clinically proven. In addition, some individuals are allergic to nonoxynol-9 and can develop a rash or sores, making them more vulnerable to infection. These individuals should be advised to discontinue use of condoms lubricated with spermicide containing nonoxynol-9, and use non-spermicidal, water-based lubricant or an unlubricated latex condom.

B. Instructions

Have clear and complete instructions on condom use available for students to take with them. Condoms purchased in the drug store have instructions on the package, along with warnings that no contraceptive is 100 percent effective. These instructions are always included because they encourage proper use of condoms, which is critical to condom efficacy. When condoms are purchased in bulk, special arrangements may be required to provide separate written instructions, as they may not appear on individual condom packages. The condom manufacturers usually will have such instructions available. They may also be willing to produce a brochure or handout specifically for your program.

These instructions should:

- include both written and pictorial directions for using the condom
- be written in language which is age-appropriate for the student audience
- be translated into languages represented in the student population: Spanish, Korean, etc.
- include information about condom effectiveness
- inform students that they must use a new condom with each act of intercourse
- inform students that if a lubricant is needed it must be water-based or silicon-based, as oil-based lubricants quickly destroy the latex in condoms
- inform students that some individuals are allergic to latex (In that case, two condoms should be used: the person with the allergy wears a natural skin condom next to their skin. For example, in heterosexual intercourse where the male partner has an allergy, he wears a natural membrane condom next to the skin, covered by a latex condom. If his female partner is allergic to latex, the male would wear the latex condom next to his skin, covered by the natural membrane condom.)
- remind students not to use the condom if it is sticky, brittle or damaged
- inform students that condoms should be stored in a cool, dry place (e.g. not in a wallet)
- advise, if either person feels burning or itching, to discontinue use and consult a doctor.

C. How Many Condoms to Order

It is difficult to estimate how many condoms will be needed for the program. If the program is effective and a high percentage of teens are sexually active, a large number of condoms will be required. For a rough monthly estimate, consider:

a x b x c = number of condoms, where:

a = Number of teens engaging in sexual intercourse who are enrolled in the school. Unless you know from local surveys what percentage are sexually active, calculate the approximate number based on the national averages (39.6 percent of ninth graders; 47.6 percent of 10th graders; 57.3 percent of 11th graders; and 71.9 percent of 12th graders reported ever having had intercourse. The U.S. Youth Risk Behavior Survey, 1990).

b = Number of condoms each student will be able to receive at each encounter.

c = Estimated average number of encounters per month.

Latex condoms generally have a shelf-life of five years if stored properly, but condoms with nonoxynol-9 have a shelf-life of approximately two years. Thus, the only significant problem with over-ordering condoms is finding space in a cool, dry location for storage.

The availability of funds is usually the major limiting factor in placing orders. Many schools rely on health departments to provide condoms, either for free or by passing on the low costs they have negotiated with condom manufacturers for bulk orders. The cost-per-condom may be as low as $.04 to $.08.

VII. BUDGETS AND FINANCING

To a large extent, the goals of the condom availability program and its design features will determine the cost of the program. The least expensive program for the school district will be one which simply makes condoms available through vending machines or open baskets. Generally, condoms themselves are the least expensive component of a program. Programs that include education, counseling, referrals, parental consent or opt-out are significantly more expensive. Some policy decisions – such as a requirement that condoms be made available only by licensed health professionals – add significantly to the cost of a program, which either must be paid by the school district or passed on to a cooperating health agency.

A. Direct Costs

The direct costs for implementing a condom availability program will include:

- condoms
- materials, including printed forms, information on condom use and efficacy
- staff (including recruitment)
- specialized training for staff
- publicity for the program
- administrative costs (including those required to implement a parental opt-out, if necessary)
- process and/or impact evaluation.

The most cost-effective method for implementing a condom availability program is to integrate it into an existing school program. Schools that have health and family life education, HIV/AIDS prevention programs or school-based health centers already budget staff time, materials, curricula and overhead for these programs. Condom availability will not add significantly to these costs.

Many schools, however, will decide to improve their health education programs and develop condom availability as one component in a comprehensive prevention plan. For example, the goal of the New York effort went beyond making condoms more accessible to reducing risk-taking behaviors and changing adolescent culture around condom use. The costs of comprehensive programs will be significant.

In developing comprehensive programs, schools should consider how to restructure their own programs and build collaborative relationships with health and youth-serving agencies in order to pool resources and provide services more efficiently. For example: the health department might provide condoms; a local youth-serving agency might provide training and education; local schools could provide staff, space and necessary administrative support; the school district could provide educational materials; and a foundation might provide additional funds. The needs assessment should help identify both resources and gaps that can help in organizing program funding.

B. Potential Sources of Funding

The simplest way to fund the program is for money to be directly allocated by the school district or health department as a function of their general budget authority. This is not always possible, since some school policies prohibit the expenditure of school district funds or because the costs of the program exceed the available resources. To supplement school district or health department funds, the design team must explore other public sources, foundations and other private sources of support.

Local, State and Federal Program Funds. In theory, potential sources of funding for condom availability programs include all local, state and federal resources directed toward teen pregnancy prevention, HIV/AIDS education and prevention, STD treatment, family life and health education.

In practice, however, there may be significant barriers to using federal or state funds for condom availability. Policy biases and regulations governing major state and federal health and education programs may inhibit or even prohibit use of these resources for condom availability programs. Competition for scarce resources may make it unlikely that any new public resources would become available.

Nevertheless, schools may be able to piece together resources creatively from various funding streams. For instance, schools might be able to save funds by administratively combining their alcohol and other drug abuse prevention programs with their HIV/AIDS prevention programs. This is logical and could improve program effectiveness, since factors which put adolescents at risk for alcohol and other drug abuse are similar for HIV, other STDs and pregnancy risks, and since alcohol and other drug use is often a factor in unprotected intercourse.

As another example, the regulations governing Title X federal family planning programs require that comprehensive services and the full range of contraceptive services be made available. Thus, it may be possible for a school-

based health service offering a range of contraceptives to arrange to become a satellite site for a Title X grantee.

The design team should explore whether the school is eligible for state or federal funds, or whether it is possible to combine efforts with representatives of local government, pregnancy prevention and AIDS organizations who receive funds through these programs.

The best way to identify potential sources of public funding is to contact:

- professionals in the field of HIV prevention and education
- the state and local health departments (specifically, adolescent health, family planning, HIV/AIDS program staff)
- the state department of education (health education specialists, the state school AIDS education coordinator, Drug Free Schools specialists)
- members of state and local adolescent pregnancy prevention and AIDS task forces
- other school districts in the state which have condom availability programs.

There are a variety of publications which list federal funding sources available. The *Catalogue of Federal Domestic Assistance* is available from the Government Printing Office (202-512-0132), and the Public Health Service's Office of Disease Prevention and Health Promotion has published *A Directory of Federal Programs and Activities Related to Health Promotion Through the Schools*. *The Government Assistance Almanac* by Robert Dumashell is available in general bookstores.

Private Sources. Some may feel that the program is best funded by grants from foundations or private contributions, so that the condom availability program does not compete for dwindling tax dollars. Local support can be particularly valuable, since it demonstrates local investment in HIV prevention. Local corporate or foundation support may, therefore, help obtain additional funds from state or federal sources.

Most school districts have experience in writing proposals and working with foundations and corporations in partnership on a specific project. Among the corporate partners that might be enlisted in the condom availability program are pharmaceutical companies, insurance agencies, medical supply companies or stores and local businesses. These companies may provide funds, donate services such as renovation, printing, public relations, training or materials, including condoms. Local medical schools or hospitals might provide staff or adopt either a school or a segment of the program.

The foundations potentially interested in supporting a condom availability program may differ from those that have traditionally entered into partnerships with schools, because of the specific focus on pregnancy prevention, HIV/AIDS and health. Some research may be necessary to determine which foundations share this interest.

Although some foundations set aside funds for emergency grants, which can be important when the program's need for funds is critical, the normal process of considering proposals can take months, with no guarantee of success. Chances of success are greatly enhanced by carefully matching the program to be funded and the foundation's interests, and by following the foundation's protocol for accepting proposals.

If possible, avoid sending a proposal without first making personal contact with the foundation. Written proposal guidelines will provide an outline of the information required by the foundation. Some foundations require a letter of intent before receiving a proposal; others will meet with contacts from the condom availability program and, if still interested, ask for a proposal.

TIPS FOR IDENTIFYING FUNDERS

People administering HIV prevention and AIDS education programs in your community can provide advice about local sources of corporate and foundation support. Investigate connections to corporate funders who may be willing to introduce or advise program administrators.

The Foundation Center in New York City (212-620-4230) assists potential applicants in identifying foundations in their areas and can provide references to the nearest library that houses Foundation Center resource material. It also produces *The Foundation Directory*, which provides information on the nation's largest foundations.

The local library should be able to provide books listing funders and their requirements. ▣

Nominal User Fees. Although cost may be a barrier to condom access for many young people, a nominal user fee would not be prohibitive for the majority of teens. If condoms can be purchased cheaply at a bulk rate, it may be possible to charge a small fee for the condoms – for instance, $.25 – and recoup the cost of the condoms and any educational materials that are provided. The least expensive bulk rates for condoms, however, may only be available to agencies that give them away.

Summary of Possible Funding Sources

- state and local health departments
- local school district, board and administration
- corporate partnerships
- private foundations
- donations of services and materials (in-kind contributions)
- local health care providers
- nominal user fees.

For condom availability as a component of HIV/AIDS education:

- Centers for Disease Control and Prevention AIDS-related funds
- State Education Department.

For condom availability as a preventive health program:

- federal categorical and state block grants providing family planning and health services:
  - Maternal & Child Health Block Grant
  - Section 330 Community Health Centers
  - Early Periodic Screening, Diagnosis and Treatment Program (EPSDT)
  - Title X, Family Planning Programs
  - Medicaid
  - Title XX, Social Services Block Grant.

CHAPTER FOUR ATTACHMENTS

A. District of Columbia Public Schools Condom Availability Implementation Plan

   1. "Summary: D.C. Public Schools' Condom Availability Implementation Plan," *WACHIVIY Special Bulletin*, September 2, 1992

   2. "How the Student Condom Program Will Work," *The Washington Post*, September 3, 1992

B. Summary, HIV/AIDS Education Training Design, New York City Schools

C. Sample Training Evaluation Form, The Center for Population Options

D. Sample Parental Consent Forms

   1. Los Angeles Unified School District

   2. Beecher Teen Health Center, Michigan

   3. School-Based Health Center Consent Form

E. Condoms Available Through U.S. Distributors

F. Components of a Comprehensive Condom Availability Training

G. Guidelines for Individual Counseling

District of Columbia School Condom Availability Implementation Plan

Goals

* To provide education and counseling on the epidemic of STD/HIV, and to encourage students to develop effective risk reduction strategies including abstinence and proper condom use.

* To provide ready availability of condoms and condom use instruction for secondary school students who wish to participate in the program.

Strategies

Grade Level Assembly Programs

* School nurses will initially introduce Condom Availability Program during the beginning of the school year orientation assembly in the context of the 1992-93 Bureau of School Health Services program.

* In addition a grade level assembly will be held during which an overview of HIV/AIDS in the District of Columbia will be conducted to define the threat of HIV/AIDS to students; discuss the effectiveness of condoms in terms of HIV and STD prevention; introduce the Condom Availability Program, and discuss how the program works from the office of the school nurse.

Education/Counseling Sessions and Continuing Staff Development

* Students will attend group or individual education/ counseling sessions on a voluntary basis, before school, after school and over lunch/free periods. These sessions will be conducted by the school nurse and peer educators when they are available.

* The nurse's office will house educational material on HIV/AIDS prevention and effective condom use.

Condom Access

* Condoms will be available as part of the counseling session and during specific periods designated by the school nurse. Each student may receive five (5) condoms each visit.

* The nurse must ensure that her office presents the students with a nonjudgemental environment.

Reprinted from the Washington Area Consortium on HIV Infection in Youth (WACHIVY), "Special Bulletin," September 2, 1992.

CPO 1993--ATTACHMENT IV.A.2

BACK TO SCHOOL

How the Student Condom Program Will Work

Starting this year, students in all D.C. public high schools will be able to get condoms from their school nurses. The new access to contraceptives was proposed by the D.C. public health commissioner in response to evidence that one in every 45 District teenagers may now be infected with the AIDS virus and 75 percent of D.C. 10th-graders are sexually active.

The District is the only Washington area jurisdiction to make condoms available in schools. But several other U.S. cities, including New York and Los Angeles, are doing so in some or most of their high schools.

The following interview with Nursing Supervisor Milliceson Hayes, who oversees all of the nurses in D.C. public schools, details how the District's program will work. With Hayes was Caitlin Ryan, chief of the Agency for HIV/AIDS, and Mary Ellen Bradshaw, chief of the Bureau of School Health Services in the D.C. Commission of Public Health. The interviewer is Washington Post Staff Writer Sari Horwitz.

The interview was conducted before Superintendent Franklin L. Smith announced Monday that parents can notify the school if they do not want their teenager to be given condoms. He also said that school officials would inform parents who object to condom distribution if a nurse or teacher learns that their son or daughter is sexually active. Public Health Commissioner Mohammad Akhter said school nurses, who work for the commission, would comply with parents' requests not to give their children condoms, but they would not betray the confidentiality of students.

PHOTO BY JAMES M. THRESHER—THE WASHINGTON POST

"Each student must be counseled before the condoms can be made available. We will also counsel the student on AIDS. Abstinence."

— Milliceson Hayes

Q: How will D.C. high school students get a condom if they want one?

Hayes: At the beginning of the school year, the [school] nurse will speak at a general assembly just to make the students aware that this service will be available this school year. After the assembly, we will ask the principals for [individual] grade assemblies. At that time, the nurse will go a little more into detail as to what a student needs in order to obtain the service. The student can then come to the health suite to see the nurse. Students can be seen on an individual basis or they can be seen in groups. Each student must be counseled before the condoms can be made available.

Of course, the nurses will be teaching abstinence as we go along. But we will make the student aware that he can protect himself or herself. A condom demonstration will be done prior to making the condoms available to any of our students. Literature will be given at the conference. A student may obtain literature without obtaining a condom.

Q: How many schools will give out condoms?

Hayes: All the high schools and [later this year] four dims.

Ryan: Not distributing. Making them available.

Q: Any particular brand?

Ryan: Right now we're looking at Lifestyle, which are FDA-approved and are the ones we have. We're always looking at the newest models that are coming out . . . I think we may have several colors. One of the issues for us has been marketing and what works well with the students. It's not going to help us at all if we give out condoms that the kids don't like, that they feel uncomfortable with. So an important piece here is actually giving them something that we know they're going to use. We know they like Lifestyles. That's been a popular brand with the young people who pack them up at our health fairs.

We try new brands all the time. We have ordered some Afrocentric brands. It has packaging that is attractive to the African American population.

Some of the condoms come in flavors and I'm told that the flavor that is most preferred at our health fairs is the mint-flavored condoms, and they come in green packaging.

We try to be attentive to the tastes and choices of

Hayes: No, I will not.

Q: Will you keep any records of who you talked to and who you gave condoms to?

Hayes: We will keep a record. But we will not use names. We will do it by numbers. That's the way we would keep the anonymity of the availability program.

Ryan: In other words, they will have a tally at the end of the day as they do with many other health issues. Five students came in today. Two students took condoms. But they wouldn't have the students' names.

Q: How many condoms does this agency have to distribute to the schools?

Ryan: We've ordered 500,000 condoms. We don't anticipate that there will be a real high volume. This is going to take a while. Students are going to have to feel that it's comfortable. There is, of course, going to be some awkwardness involved with it. We've looked at some of the other programs around the country. How many condoms have been used in the school year? And I think we estimated something like 2,500 per month in this first year of operation. Of course, if there's more, we have plenty of condoms because

were there.

Ryan: In the training, they learned how you demonstrate the use of a condom and how you do it in a way that isn't awkward. [And] about what you need to say when you're doing HIV prevention and STD prevention: You need to make sure to talk about the fact that condoms break and they're not 100 percent effective and there are certain brands of condoms that are not effective because they're porous and they have holes in them. And people shouldn't be using those kinds.

Q: Some students with whom I have spoken are concerned that their principals may discourage the availability of condoms. Do you have any sense of that at this point?

Bradshaw: Not specifically. I think that just in general one would anticipate that there may be some questions about certain schools. We're hoping that with education and meeting with people and presenting them with the facts and answering whatever questions they have that they will be able to cooperate in supporting this program. Because the overall goal is to try to protect the students from a disease that has no cure.

junior highs. Hart, Douglass, Lincoln and Evans.

Q: How did you choose the four junior highs?

Bradshaw: Those junior highs were those targeted for The Turning Points program [established as part of the mayor's youth initiative to bring a variety of special programs to junior highs in some of the most depressed areas of the city]. I think [providing condoms in all the city's junior high schools] has been mentioned as a goal by the commissioner . . . But there is no time frame.

Q: Does every school that is making condoms available have a full-time nurse assigned to it?

Reyes: Every one of the schools that is involved has a full-time nurse.

Q: You talked about counseling. What exactly will you say to the student?

Reyes: Well, it's going to be hard to say. It all depends. But we will be counseling the student on the various sexually transmitted diseases at that time, the mode of transmission for the HIV virus. We will also counsel the student on AIDS. Abstinence.

Q: What will you say to the students to persuade them not to have sex?

Reyes: (laughter) It's kind of tough.

Bradshaw: Well, abstinence is the only 100 percent way of protecting oneself against sexually transmitted diseases and HIV. It's the only 100 percent way.

Reyes: For those students who will not maintain abstinence, then I would tell the student what we do have available and that is the condom that he can use to protect himself.

Q: Is there a set speech that each nurse will give? Will there be something printed for them to use?

Bradshaw: Nurses have received quite a lot of training about both the epidemiology of sexually transmitted diseases and HIV, the whole issue of abstinence, the use of condoms, the type of condoms, the issue of certain spermicides, lubricants. The nurses have a thick manual with all that background.

There also will be a guideline in terms of what issues have to be addressed both in the conferences and the individual sessions . . . There is not going to be a speech that somebody is going to memorize and give verbatim, but there will be points that will be covered.

Q: Students that I've talked to say they do not want a lecture on abstinence. Is that basically what you will be preaching?

Reyes: No, not really. It won't be the basis, but it will be included in our presentation. We as nurses do not plan to preach to any of the students. But we do plan to get the message over as to what is occurring in our city and how they can protect themselves.

Q: How many condoms will you give to each student?

Reyes: Five per visit.

Q: Is there any limit on the number of times they can come back and get five?

Reyes: One visit per day, I would say . . . Even if a student came each day, I'm sure the nurse would counsel that student to find out why he's in need of five condoms per day.

Q: What kind of condoms are you going to be distributing?

Reyes: We're going to be distributing the latex condoms. Because we want them to use them. We want this to be part of their sexual behavior. And the only way to do this is to make it pleasant and not to make it adversive . . . That's what this is all about.

Q: What happens when you run out of condoms?

Ryan: They will call our office and one of our staff will take them over if they need them immediately. Otherwise, I think we could provide them in our monthly meetings with the nurses.

Reyes: I won't have a group of students in and no condoms there. (laughter) We'll make sure that that doesn't happen.

Q: When a student comes to you for a condom, will you notify the student's parents?

"We're hoping that with education and meeting with people . . . that [everyone] will be able to cooperate in supporting this program."

— Mary Ellen Bradshaw

Bradshaw: That responsibility really is between the parent and the student. If a student comes and asks the nurse for a condom, then the nurse will give the student a condom.

Q: Who made all the decisions about how this program will be administered?

Bradshaw: A steering committee that has been meeting regularly, which involves public health professionals, HIV/AIDS specialists, community parents, representatives from the school systems and school nurses. The committee will continue to meet throughout the year. We'll continue to look at what works and what we need to expand.

Q: Were there any students?

Ryan: Yes. They were full members of the committee. They made comments and recommendations and talked about what they felt. Oftentimes people would turn to them and say, "How do you feel about that? What do you think?"

Q: What were some of their recommendations?

Reyes: They talked about limiting the counseling sessions. Just kind of getting right down to the facts and then giving the student the condom. They asked us not to pass our personal opinions, just factual opinions. And they also asked not to have a lecture. And to listen to the student.

Q: How were the nurses trained?

Reyes: A three-day training session was planned [with] representation from different parts of the community, so we had the Sexually Transmitted Diseases (STD) Division, school health and preventive health and the AIDS office. So it was comprehensive. As well as we had a lot of folks from the community who were experts at the different hospitals and at community-based organizations we fund. Part of it dealt with multicultural issues. And all of the nurses will be participating in and making them available to the community.

We get a special bulk rate. It ranges, according to the condom, between 6 and 9 cents a condom. We order them directly from the manufacturer.

Q: Do you have any long-term plans to install condom dispensing machines in the schools?

Bradshaw: That has been discussed. But I think that's probably a budgetary issue . . . And the personal interaction has advantages.

Q: What other AIDS education plans do you have for D.C. school students this year?

Ryan: We fund a lot of community-based AIDS organizations in the District. One of them is Lifelink, a speaker's bureau for people with AIDS. I've talked with Lifelink about their availability to go and speak in assemblies about their experiences. There are some younger folks, some people in their teens who are HIV-infected who would be available to come and speak. One of the things that has been very effective is when young people hear a young person with HIV infection or AIDS speak. That really brings the message home like nothing else does. We also have videos that we're going to be making available.

Bradshaw: There is a health education curriculum in the D.C. public schools and an HIV/AIDS education part of that. And the office of HIV/AIDS activities has a responsibility for ensuring that that curriculum in particular is made available in the schools.

Q: What will you do if parents object to their son or daughter getting a condom?

Q: Do the nurses have any specific concerns about the plans?

Reyes: They had some concerns in the beginning about the principals, how the principals would feel. But I think those fears have been alleviated. A number of principals are coming forward with positive responses. So the nurses are all ready to go.

Ryan: I think the most important thing for people to understand is that the HIV infection will be with us for years to come. For at least the next 40 or 50 years. We have to socialize whole generations of young people into low-risk and no-risk behaviors. Prevention is the only answer. It's the only way to stop HIV infection.

"We have to socialize whole generations of young people into low-risk and no-risk behaviors. Prevention is the only answer."

— Caitlin Ryan

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Summary HIV/AIDS Training Design, New York City Schools

New York's design comprises three layers of training, an orientation, and two more advanced sessions. Only those personnel who actually make condoms available to students are required to complete all three trainings. Other school personnel, parents and students on the HIV/AIDS education teams are invited to attend the orientation and first advanced session.

New York developed two versions of the orientation session, one for large groups that have the space to split up into separate rooms and one for large groups that must stay together in an auditorium.

Orientation Session With Break-Out Rooms (9:20 a.m. - 12:50 p.m.)

I. The session begins with greetings and overview of the day presented by high-level school administrators and community leaders.

II. A keynote address is delivered by an expert with high credibility in the community. The address provides current information about the range of adolescent behaviors, sexuality within the context of adolescent development and HIV and adolescents.

III. A panel of people living with HIV is presented.

Each school's team then meets in a separate room with its own facilitator(s).

IV. Icebreaker exercise is led that has participants pair up and "interview" each other in order to uncover and share personal and professional concerns.

V. A quick needs assessment in performed by asking participants to brainstorm things that are needed to make HIV/AIDS education and condom availability effective. This list should include their personal concerns.

VI. A role-play activity is done in which a facilitator plays a student, a volunteer participants plays a staff person and another volunteer records on newsprint points that are raised during the role play. Other participants observe. After the players debrief, discusses their reactions to the role play. The purpose of this initial role play is to begin to raise issues and feelings, not draw conclusions.

VII. Multi-cultural issues in conducting HIV/AIDS education for different racial/ethnic, religious and sexual orientations groups are identified.

VIII. Participants are given tasks to complete before the next level of training. These include: review their school's HIV/AIDs plan; read the written policy document; meet as a team to clarify the school's progress.

Orientation Session Without Break-Out Rooms (8:30 a.m. - 1:00 p.m.)

School teams are seated together by a seating chart arranged in advance.

I. A program overview is given by a high-level school administrator, a student representative and a principal or HIV/AIDS team leader from a school already implementing the program.

II. Several youth presentations are made to increase awareness of the impact of HIV on adolescents, their families and the community. Drama, music, poetry can be used.

III. A keynote address is given by an expert in adolescent development and behavior, focusing on sexuality within the context of adolescent development.

IV. Additional youth presentations are made.

V. A second keynote address is given by an expert, focusing on the incidence of HIV/AIDS in New York City and the impact of HIV/AIDS on the lives of adolescents.

VI. Additional youth presentations are made.

VII. In teams, participants use an icebreaker exercise to discuss their personal concerns about AIDS, their strengths as HIV/AIDS educators and so on.

VIII. In each team, a facilitator leads a brainstorming session in which participants make a list of things that are needed to make HIV/AIDS education and condom availability effective. This list should include their personal concerns as well.

IX. In a closure activity, the entire group sings along with a student theater group.

Tier I Training (8:50 a.m. - 12:00 p.m.)

Participants in this next level of training include: each school's HIV/AIDS teams, including principals, assistant principals, teachers, students, parents plus condom availability staff volunteers.

I. In a greeting and overview, administrators congratulate the teams, praising their collaborative effort.

Reprinted courtesy of the New York City Board of Education.

II. An administrator presents the policy - which participants have read and reviewed.

III. An expert in adolescent behavior and development delivers a keynote address focusing on sexuality as one of many adolescent issues and the spectrum of adolescent sexual behavior, including abstinence.

IV. A very meaty update on HIV/AIDS is given in a lecturette format, with ample opportunity for participants to brainstorm and ask questions. Those participants who will take the Tier II training are given a homework assignment to bring a condom home.

V. The group is broken up into dyads to discuss building and strengthening resources.

Tier II (Two days, 8:50 a.m. - 2:5 0 p.m.)

Participants are the condom availability staff on the school's HIV/AIDS teams, plus the HIV/AIDS team leader or other administrator. Since under New York City's plan, only school employees can make condoms available, no parents or students are present.

Day One

I. Ground rules are established.

II. A policy review is conducted, focusing on concerns emerging from the Tier I policy session.

III. An exercise to stimulate participants' adolescent memories is carried out and processed.

IV. Participants are asked to examine the environment in which today's adolescents live by brainstorming all the things adolescents today have as part of their world that adults today didn't have to face.

V. A good chunk of time is devoted to role plays that help participants: identify the range of issues that have an impact on adolescent sexuality and decision-making; learn guidelines for effective communication with adolescents; and explore how personal values, attitudes and beliefs affect how we communicate with adolescents.

VI. In this section, participants have an opportunity to increase their comfort in talking about condom use and misuse. The homework assignment to take a condom home that was made in the Tier I training is discussed. The questions focus on: what did they do with it? Why? What happened? Who did they talk about it with? Why? If they didn't do anything with it or talk about it, why not? This discussion leads nicely into the next section on influences on communication and language.

VI. Participants explore language by having small groups discuss words like abstinence, sex, sex partner, and virginity. In the large group processing session, the facilitator asks participants to think about what influences our definitions of these words (personal experience, culture, knowledge, etc.). The point is made that when talking to adolescents, we need to be certain that they understand our message and we hear their concerns, through the filters of personal experience, culture, knowledge and other factors..

VII. Participants have the chance to review the printed material given to students and to ask technical questions.

VIII. Steps of proper condom use are reviewed by distributing large cards with steps written on them to participants. The participants than have to line themselves up in correct order.

IX. At the close of the first day, Condom Hunt Homework is distributed (SKF, let's include ours)

Day Two

I. Review of homework that allows participants to reflect upon their experience buying condoms and thus come to a better understanding of the obstacles adolescents face in purchasing condoms.

II. Having reviewed the steps of proper condom use the day before, this is the time for each participant to pair up with a partner and explain and demonstrate how to use a condom.

III. Participants role-play students in a variety of relationship situations in order to help them gain condom negotiation skills.

IV. Participants are asked to brainstorm all the psycho/social/health needs that students present. The group then breaks into three smaller groups to discuss the needs under each category, identifying school-based and community resources that can assist school personnel in helping students.

V. In the last exercise of the training, participants design the ideal community support system, both in-school and out-of-school. They then select three things they believe can be accomplished and devise strategies to do so.

VI. Participants are asked to evaluate the training.

For a copy of the entire training design, please contact:

HIV/AIDS Education Program
131 Livingston Street, Room 200
Brooklyn, NY 11201

phone (718) 935-5606
fax (718) 935-5197

Sample Training Evaluation Form,
The Center for Population Options

1. What were your expectations for this training?

2. Were these expectations met? How and why?

3. Did you learn anything in this training that you did not know before attending?

   If yes, what?

   Do you know how you will incorporate this new information into your work? How?

4. How many people do you expect to reach in the next year with the information from the training?

5. Do you have questions or concerns that were not addressed at the training?

   If yes, what are they?

6. What was the most valuable portion of the workshop?

7. What was the least valuable portion of the workshop?

8. Do you have suggestions for how the training could be improved?

   Suggestions for future sessions?

Sample Parental Consent Form

LOS ANGELES UNIFIED SCHOOL DISTRICT
HIV/AIDS PREVENTION PROGRAM
PARENT/GUARDIAN CONSENT FORM

Dear Parent(s) or Guardian(s):

HIV/AIDS and sexually transmitted diseases are epidemic in our community. Public health statistics and reports indicate that increasing numbers of young people in their early teens are becoming involved in behavior that puts them at risk for infection. While the district does offer education which emphasizes abstinence as the only one hundred percent effective method of preventing infection, the proper use of a condom does provide some protection against sexual transmission of the HIV/AIDS virus. At the urging of medical and public health authorities, the Board of Education has enacted a policy to make condoms available for students,subject to the parental approval guidelines currently used for Health Education classes.

Condoms will be made available through the school to students requesting them unless you, as the parent or guardian, withdraw permission by completing and returning the tear-off below. In making condoms available, the District assumes no liability.

If you do not wish your son/daughter to be able to obtain condoms through the school's HIV/AIDS program, please return this form by _____.
(Date)

_____
(Principal)

HIV/AIDS PREVENTION PROGRAM

To: (Name of Principal) Date:
(Name of School)

I <u>do not</u> wish my son/daughter to obtain condoms through the school's HIV/AIDS Program.

_____ _____
Name of son/daughter Signature of Parent/Guardian

( )_____
Daytime telephone

Sample Parental Consent Form

BEECHER TEEN HEALTH CENTER

PARENT CONSENT FORM

Beecher 103 is a health center for adolescents located in room 103 at Beecher High School. Beecher 103 is staffed by a pediatric nurse practitioner, a medical assistant, a mental health counselor, a health educator, and pediatricians from Mott Children's Health Center. Your teen can get full service health care during and after school. We are open Monday through Friday from 10 a.m. to 6 p.m. The clinic is also open during the summer and on school holidays.

- Any adolescent, ages 10-19, living in Genesee County is eligible for services. Beecher teens receive first priority.
- There is no charge for services. We will bill your health insurance plan when possible.
- Beecher 103 is funded by Mott Children's Health Center, The Michigan Department of Public Health and the Beecher Schools. For more information, call B.103 at 785-9689.

YOUR TEEN CAN GET THESE SERVICES AT B.103

- COMPLETE PHYSICALS
- SPORTS PHYSICALS
- SICK CARE
- REPRODUCTIVE HEALTH EXAMS
- HEALTH EDUCATION PROGRAMS
- SKIN AND NUTRITION CARE
- LAB TESTS AND PRESCRIPTIONS
- COUNSELING
- HEARING AND VISION SCREENING
- MEDICAID SCREENING

==========

I give my consent for _____ (name) _____ (birthdate) to receive health and medical care, counseling and any treatment related to these services at the Beecher Teen Health Center.

I hereby authorize the BTHC to release information in the patient's medical record for payment of insurance benefits to BTHC.

_____ _____
Signature of Parent/Guardian Today's Date

_____ _____
Address Phone

I do not wish my child to have the following: _____

_____

Michigan law does not require parental consent or advice for treatment of drug abuse, alcoholism, sexually transmitted disease, pregnancy or contraception.

I understand that testing for blood borne diseases, including HIV (AIDS), may be performed upon a patient without a separate written consent in the event that a health care professional from B.103 or Mott Children's Health Center sustain exposure to blood or body fluids from the patient's open wound, percutaneous mucous membrane or occupational hazard.

Beecher Teen Heath Center. *Parent Consent Form.* Flint Michigan: Beecher Teen Helath Center, a program of Mott Children's Health Center, 1992. Reprinted with permission.

HEALTH AND INSURANCE INFORMATION

Teen's Date of Birth: _____ Grade: _____

Race: _____ Sex: _____

Transportation to school (bus, walk, parents):_____

Known allergies: _____

Current medications:_____

Chronic illnesses: _____

Do you have a regular doctor or clinic? [ ] yes [ ] no

If yes, please complete the following:

Doctor's name: _____

Address: _____

Phone: _____

When was the student's last visit? _____

Do you have health insurance? [ ] yes [ ] no

Name of the medical insurance company: _____

Address: _____

Phone: _____ Subscriber's date of birth: _____

Effective date: _____

Card numbers: _____
(Group Number) (Contract Number)

Do you have Medicaid? [ ] yes [ ] no

If yes, please complete the following:

Card number: _____ Expiration date: _____

Name on card:_____

Sample Parental Consent Form

I grant permission for my child to enroll in the ____ School Health Program. I further consent and authorize the ____ Teen Health Center to provide treatment to (Patient's Name) _____ (Birth Date) _____, including but not limited to, examination, lab tests, family planning services, medicines, as may be considered necessary in the judgement of the physician and health care staff. I further consent to and authorize mental health/substance abuse treatment as may be considered necessary in the judgement of the health care staff. I understand that I can withdraw my consent at any time through written notification.

_____ DATE

_____ SIGNATURE OF PARENT, GUARDIAN OR PATIENT 18 YEARS OR OLDER. (Please circle the appropriate title.)

_____ HOME PHONE NUMBER

_____ WORK PHONE NUMBER

_____ STREET ADDRESS CITY STATE ZIP

STUDENT MEDICAL HISTORY:

Allergies, including reactions to medicine (if any):_____

_____

Medical illness (past/present):_____

_____

Current medication:_____

Name of family physician (if any):_____

Phone number:_____

In case of emergency, please contact:_____

NAME RELATIONSHIP

_____ PHONE NUMBER

Insurance information:

Private Insurance:_____ COMPANY NAME

Medicaid Number: _____

No Insurance: _____

Please drop off or mail to: _____

The ___ Teen Health Center provides high quality health care to adolescents and encourages involvement of teens and their families in the health process.

Condoms Available Through U.S. Distributors

Ansell Medical Products
P.O. Box 1252
Dothan, AL 36302
(205) 794-4231

Carter-Wallace
Order Entry Department
Half Acre Road
Cranbury, NJ 08512
(609) 655-6000

Finley Company
1643 S. Research Loop
140
Tuscon, AZ 85710-6755
(607) 722-3939

Mayer Laboratories
231 Fallon Street
Oakland, CA 94607
(510) 452-5555

National Sanitary Labs, Inc.
4433 West Touhey Ave.
Suite 402
Lincolnwood, IL 60645
(708) 982-1700

Okomoto USA, Inc.
18 King Street
Stratford, CT 06479
(203) 378-0003

Saftex
16101 Continental Blvd.
Colonial Heights, VA 23834
(804) 520-8341

Sagami, Inc.
8725 W. Higgins Road
Suite 481
Chicago, IL 60631
(312) 399-1111

Schmidt-Ramses
City Center
1819 Main Street
8th Floor
Sarasota, FL 34236
(800) 827-0987

Suma Trading/RIA
3221 N. Figueroa Street
Los Angeles, CA 90065
(213) 222-9848

COMPONENTS OF A COMPREHENSIVE CONDOM AVAILABILITY TRAINING

- **Information about adolescent development and behavior.**
  Adolescents' cognitive, social and physical development affect their sexual behavior and their likelihood of taking risks. Information about those developmental stages and the opportunity to reflect upon the challenges and joys of working with this age group reinforce what participants already know.

- **Information about HIV/AIDS.**
  Introductory information, often termed "AIDS 101," is necessary and should be reviewed. Topics include: the difference between HIV and AIDS, transmission, prevention and testing.

- **Information about adolescents' risks for pregnancy and all sexually transmitted diseases (STDs), including HIV.**
  Pregnancy and STD rates are soaring in the adolescent population. Many of these STDs increase the risk of HIV transmission. The number of unwanted pregnancies in any school community can be a good indication of how much unprotected sexual intercourse is occurring.

- **Opportunity for participants to reflect on their own values and experiences to examine how these might enhance or interfere with this work.**
  Activities and discussions designed to encourage participants to honestly consider their personal feelings and values about issues related to sexuality, communication and condoms are important. If participants have the opportunity to "own" their feelings and values, they can determine how those factors might affect their work. With that knowledge, they can then decide how they can work most effectively.

- **Opportunity for participants to consider pressures students face today.**
  Adolescence is not an easy time, and all adults can recall the difficulties and challenges of their own adolescence; giving participants a chance to do so might be helpful. In addition, however, it is important to give participants the chance to think about the new pressures facing today's adolescents so that they can put HIV and pregnancy prevention in context.

- **Information about effective counseling and communication techniques to use with young people and the opportunity to practice them.**
  Talking with young people about intimate issues of sexuality is not easy for most people. Having the chance to think about how to be an approachable adult who can communicate effectively with teens is an essential part of any training designed for those who will counsel students. Role-plays that allow participants to practice good listening and counseling skills are an effective tool.

- **Opportunity for participants to increase competency in dealing with various racial, ethnic and gender groups.**
  Students come from all kinds of racial and ethnic backgrounds. Male and female students have different needs and expectations. Participants should have the opportunity to reflect on cultural and gender differences among these groups and to move beyond a mere "appreciation" for diversity. Rather, the training should provide the chance for participants to think about steps they can take to increase their competency in dealing effectively with students from all groups.

- **Information about the needs of gay, lesbian and bisexual youth.**
  There are gay, lesbian and bisexual youth in all schools. They are often the most persecuted members of the school community because of society's sanction for anti-gay feelings and behavior. Participants need accurate information about homosexuality and the needs of gay, lesbian and bisexual adolescents, as well as the opportunity to consider how they can act as allies to these students.

(Continued)

COMPONENTS (Continued)

- **Information about condom use/misuse and the opportunity to practice demonstrating proper condom use.**
  A key component to any training designed for those who will actually counsel students about condoms is information about proper use. Each participant should have the opportunity to handle a condom and demonstrate how it is used.

- **Information about barriers to condom access that young people face.**
  In order to understand the rationale behind a school condom availability program, participants should know the barriers to condom access that students face. Those barriers include: expense, lack of sites for free or reduced-price condoms, lack of confidentiality, embarrassment and others.

- **Opportunity to explore condom negotiation skills.**
  Providing students with condoms is, of course, only one part of a complex strategy for decreasing students' health risks. A condom is useless unless it is used. It is imperative that participants who counsel students have the opportunity to think about and practice teaching condom negotiation skills.

- **Opportunity to obtain information and clarification about the school's condom availability policy and practices.**
  It is a good idea to have a person in each training who is an official representative of the school to answer questions about the program. It is also helpful to provide a written document outlining the program and its procedures.

- **Opportunity to develop an implementation or work plan.**
  It may be useful for participants to have some time to meet with others they will work with to design a reasonable plan of action.

- **Information about appropriate resources for referrals and assistance.**
  Many issues might come up in a counseling session; participants who will counsel should have information about where they can turn for help and where they can refer students.

- **Information about any record-keeping that will be required and its importance for process evaluation.**
  Those participants who will be directly involved in implementing the program should be informed about the kinds of record-keeping they will be expected to conduct.

GUIDELINES FOR INDIVIDUAL COUNSELING

1. Applaud the student for taking responsible action in accessing the condom availability program.
2. Talk with the student about his or her past contraceptive behaviors. What methods were used? Did he or she like the method? What problems did he or she encounter with the method?
3. Reinforce that condoms not only lower the risk for HIV and other STD transmission, but also lower the risk of pregnancy.
4. Discuss that while nothing but abstinence is 100 percent effective, latex condoms can be very effective when used correctly.
5. Explain that a condom should be used with a lubricant such as a spermicidal foam to reduce the likelihood of breakage. Foam will also increase condom effectiveness against pregnancy to 98 percent.
6. Try to uncover any history of latex or nonoxynol-9 allergic reactions. If the student is allergic to nonoxynol-9 do not suggest using foam or a spermicidally-lubricated condom. If the student or their partner is allergic to latex, two condoms should be used: the person with the allergy wears a natural lambskin condom next to the skin, covered by a latex condom.
7. Demonstrate how to unroll a condom. If a plastic model is not available it is easy to demonstrate on two fingers. Explain the importance of putting on the condom before any penetration occurs. Demonstrate how the condom should be rolled down over an erect penis, leaving a small (1/4 inch) space at the tip of the penis in which the semen can accumulate after ejaculation (some condoms have a receptacle end that provides that space). It is also important to explain that, after sexual intercourse, the condom should be held at the base of the penis and the penis withdrawn before it becomes flaccid.
8. Discuss whether the student's partner is willing to use condoms. Have they talked about using protection? Try to assess and enhance the student's level of comfort in negotiating condom use with his or her partner.
9. Be open to signs of underlying issues that the student may need to discuss. Be honest if you need to refer the student to another source for help.
10. Give the student a chance to ask questions. Assure him or her that you are open to answering anything you can. Watch your body language and facial expressions — adolescents can read people very well.
11. Relax and enjoy the interaction. Students know that you are human. They mostly need an accepting ear.

CHAPTER FIVE

EVALUATION STRATEGIES

Evaluation, including needs assessment, is a critical component for condom availability programs. A comprehensive evaluation that complements each phase of the program, from the planning stages onward, can furnish information to document the need for the program, track the implementation process, summarize the effect of the program and suggest avenues to strengthen or refine programmatic activities.

The importance of planning an evaluation up-front cannot be over-stressed. Because condom availability programs are both innovative and controversial, communities must substantiate need and prepare for opposition, position the program for support and compete for resources. Observers will expect to see a variety of results over time – proof that the program has succeeded, that the community supports it, that the primary business of the school is not in some way disrupted. To speak adequately to these issues, the evaluation plan must be operational when the program begins.

This chapter covers the basic considerations for designing an evaluation strategy for a school-based condom availability program. It also addresses three key issues: documenting the need for the program, anticipating evaluation during program planning and evaluation design. The Resource List in Chapter 9 includes a section on where to get help with evaluation design and execution.

I. EVALUATION APPROACHES

Evaluation is a collective term for techniques and approaches used to characterize and assess program activities. There are basically three types of evaluations: needs assessments, process evaluation and impact evaluation. Each serves a specific function and should be undertaken at various times during a project. A **needs assessment** should be conducted very early in the discussion process to determine whether a problem exists in the community for which a condom availability program could be part of the solution. At a slightly later time, planners may need to gather additional information in order to develop the program. Needs assessments can also provide baseline data to later assess impact.

A **process evaluation** should be conducted the first or second year of the operation. It provides the opportunity to assess the quality of services provided to students, while simultaneously monitoring the day-to-day operations of the program. It is important to undertake an **impact evaluation** only after the program has been operating for several years, as time is needed to establish a clientele large enough to measure the impact of a program. (See "Getting Help with Evaluation" in Section V for more information about professional assistance.)

II. ESTABLISHING NEED FOR THE PROGRAM

Documenting the need for a program serves a variety of purposes. It provides a foundation for planning, identifies pockets of support and opposition, raises new questions or considerations that can ultimately strengthen the program and yields baseline information on the current status of the youth population and community. The assessment of current circumstances and needs can be conducted simply to address the particular goals of planning the condom availability program or it can be broadened to comprehensively address adolescents' health status.

A. Needs Assessment

The goals of a needs assessment are to determine whether there are adolescent health problems in the community, what resources are available to help with those problems and whether these problems could be addressed by comprehensive sexuality education and sexually transmitted disease (STD)/HIV/pregnancy prevention programs that include condom availability in the schools.

A needs assessment takes time but is worth it. Information gathered during this process will allow the community to assess: teenagers' difficulty accessing information and health services, community attitudes toward school-based solutions and the allies and opponents of condom availability. A needs assessment should provide sufficient information to guide planners in designing an effective program.

One of the first tasks is to gather state and local statistics on the prevalence of adolescent pregnancy and STD/HIV infection. The state department of health and the Bureau of Vital Statistics should have this information, listed most probably by state and county rather than by local school unit. While recent data is important, one should also look for trends. Are the rates going up or down? How does the community look relative to others in the state or in the nation? Racial differences in pregnancy rates have been well-documented and should be taken into account in doing an assessment and in making comparisons.

Local sources will have data that is probably less accurate but important in building a case for condom availability. How many pregnancies are known to the school principal, counselor, social worker or school nurse? If the school is not already keeping data about whether teens drop out of school because of pregnancy, this is an appropriate time to begin such data collection. If there is a peer program in the school that focuses on teen health issues, the peer educators can be asked how many pregnancies are known to them. The local health department, family planning clinic and HIV/STD testing sites should have statistics about the number of adolescents who use their services and what percentage of teens' test results indicate they are infected and/or pregnant.

There are many methods of gathering information from diverse sources and each has a specific usefulness. At the very least, the needs assessment should include one method that accurately and objectively summarizes the viewpoint of a population and one that provides more detailed and specific, albeit subjective, information. Respectively, surveys and focus groups provide just that. These two information gathering techniques are summarized below.

B. Surveys

Conducting surveys requires professional knowledge about design, sampling and analysis. A graduate student or professor at a local university might offer assistance for a reduced fee or in exchange for access to the data for their professional use.

Conducting a student health survey also helps illustrate the need for condom availability. In most school districts, a survey will require the approval of the superintendent or administrator. If that is not forthcoming, survey teens enrolled in community-based programs or at places such as shopping malls, cinemas or recreation centers. In a small community or in some neighborhoods, those conducting the needs assessment may be able to identify the local "hangout" and distribute questionnaires there.

Results based on this type of sampling cannot be portrayed as representing the entire student body but, with some effort to reflect the racial, ethnic, gender and class differences of the student body, they will be helpful.

When surveying students, it is important to ask not only questions about whether they are sexually active, how consistently they use protection and what information they have about pregnancy and disease prevention, but also about their attitudes and values. The survey should ask specifically about condom availability (which stores, where in the store, etc.) and barriers to use (cost, embarrassment, etc.). Also, the survey should ask whether students know they can buy condoms and other contraceptives without parental consent.

The survey questionnaire might also include questions on a variety of health areas, including access to health services and insurance, use of health services, health problems or concerns (including mental health problems, nutrition and exercise) and risk-taking behaviors such as unprotected sex or substance use or abuse. The survey should also obtain background or demographic information to identify which groups of students are most in need (e.g. information about gender, neighborhood, age, ethnicity or family income). It is essential that participants' anonymity be guaranteed; surveyors or interviewers should not know interviewees, not ask for names and should conduct the survey or interview discreetly.

Although parents have less information about students in some areas (e.g., risk-taking behaviors), they have more knowledge of other types of information (e.g., availability of health insurance and access to health care providers). Thus, a survey of all parents (or a representative sample of parents) may usefully supplement the student survey.

If parent surveys are to be reasonably representative, parents and guardians need to be accessed directly. Do not rely on sending surveys home with students. Mailing surveys is the most cost-effective means of gathering parental opinions. If you choose this route, however, understand that only parents who are motivated to return the survey will do so, yielding biased results. This is also a problem in areas with low adult literacy rates. Telephone interviews require more staff time, but generate less biased responses. They exclude families with no phone service. Door-to-door interviews are the most costly, but reach the widest range of parents and adults in the community. This method, however, requires a larger number of interviewers, time and transportation arrangements. A combination of approaches will often yield the best results. Telephone interviews can augment mailed surveys. Door-to-door approaches can be used in segments of the community that are hard to reach. Generally, a more diverse population will require a more diverse set of survey approaches. Take care to use surveyors and other adults who are acceptable to each community.

Finally, parents can also be interviewed at malls, grocery stores or other public places. Face-to-face interviewing strategies require time to collect data and help from experts in planning the approach and training the interviewers.

C. *Focus Groups*

Another way to gather information is through the use of focus groups. Focus group research consists of a series of structured discussions on a specific topic or issue with a small number of participants led by a moderator. Focus groups, a mainstay of market research in private industry, provide an easily accessible

way to collect qualitative information about how a specific audience perceives a topic, program or product. The discussion format can result in a friendly, trusting atmosphere that encourages personal disclosures and allows communication among participants that is not available in surveys.

The ideal group size ranges from six to ten participants who are homogeneous with respect to a chosen set of background characteristics. As a guide to selecting homogenous groups, consider which key segments of the community will be concerned about or affected by the program. For example, students, parents, teachers, school administrators and health professionals represent five distinct segments of the community. Generate focus groups from each segment.

The researcher also needs to consider groups made up by demographic characteristics such as gender, race or school catchment area. As one makes groups more specific and homogeneous, however, an ever larger number is needed to represent the community. To get the best possible overview of community response, conduct two to four groups with each key segment of the population. Schools, community groups, health organizations and parent groups can identify participants. As suggested above, community-based organizations, peer programs and sites where youth gather provide access to young people if the school is not willing to cooperate.

Once the participant audience has been identified, develop a focus group protocol: a list of questions relating to the basic topic or area of concern. A good strategy is to start with general questions, move to more specific questions (including those that are most controversial or difficult to answer) and end with questions that stimulate summary discussions and conclusions. For example, begin with broad questions on reproductive health issues and adolescents; move to questions specifically related to risk-taking behaviors and prevention strategies (including condom use); finish by determining what strategies seem appropriate to the participants and under what conditions they would find them acceptable. The protocol for each key segment of your population will differ based on the type of information and expertise each has to offer.

At the outset of any focus group, the moderator should specify the purpose of the group, make introductions and cover logistics (including consent procedures), assure confidentiality and lay out any ground rules.

During the session, the moderator poses questions and encourages discussion in as unbiased a manner as possible. If more than one person conducts the focus groups, the moderators should be trained to administer the protocol consistently. Moderators should strive for a response from at least three different people for each question, probe for deeper clarity when appropriate and curtail discussions that become tangential. The moderator should make certain that one person does not dominate the discussion and should help the group avoid falling into debates. The moderator should not take notes and, if possible, should not be responsible for the record-keeping system.

Logistics are critical to successful focus groups. Choose a setting that is comfortable and accessible to the participants, where the room can be structured to facilitate open communication (a circle of chairs or desks, or a large meeting table). Select a time that is convenient for the group. Students can sometimes meet during school hours or, more likely, directly after school; parents may prefer evenings or weekends. Serving light refreshments enhances the informal feeling. Time the group so that it runs between one and two hours. If the session gets too long the quality of the responses will suffer.

Use audio or video cassettes to record responses. Once the focus groups are completed, the tapes must be transcribed for analysis. The main method includes comparison of responses and counting the number of similar references (content analysis). The more simple and brief the focus group protocol, the easier it will be to analyze the data and develop conclusions for each group.

Use the information from focus groups to develop the program, to assess the progress of the program and to provide guidance for developing more quantitative approaches, such as surveys, which can be used with a larger number of people.

Most organizations will need help in designing a focus group plan. Included in the Resource List (Chapter 9) are suggestions on where to get help with evaluation in general. Additional resources for conducting focus groups can be found in the business community, particularly in the areas of advertising and market research. Although the organizations listed might not be familiar with health issues, they can help coalition members gain a better understanding of how to use focus group research and can help with planning and logistics.

III. CONSIDERING BROADER HEALTH ISSUES

Establishing that the community has a problem with HIV/STD infection and teen pregnancy is the very minimum needs assessment that should be conducted to demonstrate the need for a condom availability program. If at some point the school or community plans to consider a broader range of adolescent services, it might be useful to expand the needs assessment beyond STDs, HIV and pregnancy and examine broader issues of student health and well-being.

The Center for Population Options' (CPO) *School-Based Health Centers: A Guide to Implementing Programs* suggests collecting information about the following topics:

A. Health Problems

How prevalent are health problems among adolescents in the community? In addition to gathering the rates of pregnancy, birth and STD/HIV infection, determine the following:

- How many adolescents have acute conditions (illnesses of a short duration)?
- How many have chronic conditions (illnesses that persist)?
- How common are risk-taking behaviors such as alcohol and drug use?
- What is the school absentee rate? How much can be attributed to illnesses?
- How frequently do adolescents rely on emergency room visits in area hospitals?
- How common are acts of violence committed by and on adolescents?
- What are the mortality (death) rates and incidence for vehicular and non-vehicular accidents?
- How many students suffer from eating disorders, from diet deficiencies? How many are under or overweight?
- What are perceptions of the norms, such as how many students do they think are having sex, using condoms, etc.?

B. Psychosocial Problems

- How prevalent are psychosocial problems among young people?
- How frequently do young people seek help at local mental health facilities for stress, depression, loneliness or suicidal feelings?
- How frequently do counselors, teachers, social workers notice these conditions among students?
- Does professional training include how to recognize these problems?
- How often are family problems, including physical and sexual abuse and parental substance abuse, identified by school counselors or social workers?
- What is the number of outpatient/mental health/substance abuse visits made by teens?
- What is the teen suicide rate?

C. Health Information

- Does your school district have a K-12 health curriculum? How comprehensive is it?
- Is information about various health conditions available somewhere in the school? Nurse's office? Counselor's office? Library?
- Do students know how to find answers to health questions?
- Do students know how to find resources to meet their health needs, both at school and in the community?

D. Health Access

To determine where adolescents can access medical resources, consider the following:

- Are family planning and STD clinics readily accessible to teens both in terms of location and hours?
- Do teens know that they can receive health care confidentially?
- Is there a school nurse? How available is the nurse? What services can the nurse provide to students?
- What percentage of students has a family doctor? How many would use the family doctor for reproductive health needs? For substance abuse issues?
- Are doctors, specialists in adolescent medicine, clinics (private and community), emergency rooms, mental health and substance abuse practitioners readily accessible to meet the needs of teens?
- What is the average waiting time for an appointment with any of the providers listed above?
- How many students are eligible for Medicaid?
- How many students are covered by health insurance?
- Has the federal government categorized the region as a medically underserved area or as an HMSA (health manpower shortage area)?
- Does the community have innovative programs designed to meet the health needs of teens? Other innovative programs for teens?
- What are the gaps in the health care delivery system experienced by students?
- Do students make their own appointments or do they need to ask for a medical card, number or form?

E. School and Community Considerations

- What is the drop-out rate?
- What are the reasons students drop out?
- What is the grade-to-grade failure rate?
- What percentage of students is not at grade level?
- How many students are suspended from school because of fights or violence? Because of substance abuse? Because they are carrying a weapon?
- What is the crime rate in the community? Among teenagers? How many young people are arrested? For what?
- What is the poverty rate?
- What percentage of teenagers lives in families with income below the poverty level?
- What percentage of students lives in single parent households?
- What is the unemployment rate for adults? For teens?
- What percentage of students lives on the streets or in families who are homeless?
- How many students have English as a second language?

Some of this information is readily available from the school, the police department and community health and social service agencies. Some is available from county or state departments of education, health or human services. Some will be harder to research. Other information sources include local agencies (police, social services, etc.), local foundations and research firms. Sometimes community-based organizations and youth-serving agencies have already gathered these kinds of data or can provide you with appropriate leads. If all else fails, survey local experts in these areas to get their opinions on problems when facts are lacking.

It is not necessary to gather every piece of information suggested above. What is necessary, however, is sufficient information to make the case that the goal is appropriate to meet the needs identified. Although proponents may have decided in advance that a condom availability program is desirable, unless there is a demonstrated need for such a program, chances for success are slim.

After gathering this data, identify the general problem areas, such as barriers to condom use or inaccessibility to health care, and generate possible solutions. Keep in mind the perspectives of the administrators, teachers, students and parents involved. The goals and objectives necessary for program planning may become apparent or may be generated from this early needs assessment.

IV. GOALS AND OBJECTIVES: THE DRIVING FORCES BEHIND EVALUATION

In reality, evaluation design is dictated by the program planning process. During the early stages of program planning, while crafting the goals and objectives, determine the evaluation potential of the program. Those program objectives should provide a road map for the process and impact evaluation design. Therefore, it is imperative to set clear, measurable goals and objectives for any condom availability program. These should be clearly written, and ways of measuring the services and impact determined.

Setting attainable goals to obtain measurable objectives is critical to the success of the program. Chapter 4 describes a goal as "a long-term planned accomplishment for a program." Make the goal statement broad to encompass all aspects of the project. It is important to distinguish between a *goal*—which is realistic, attainable and measurable— and a *vision* (or mission statement) which represents the ideal toward which the program aims.

Consider the experience of adolescent pregnancy prevention programs. Over the past two decades many pregnancy prevention programs have specified a measurable reduction in pregnancies as their goal. Teen pregnancy is associated with a wide range of variables, most of which are completely out of the control of programs. A variety of changes on the part of individuals and society are required to reduce these rates. Even if all factors could be isolated and accounted for, collecting all the information necessary to determine whether any change has occurred can be nearly impossible.

A more workable strategy is to identify "the reduction of unplanned teenage pregnancies" as a vision or mission statement. Programs would then select goals that reflect changes in education, awareness, attitudes or specific interim behaviors (e.g., postponing sexual intercourse or increasing the prevalence of contraceptive use).

The same principles apply in selecting a goal for condom availability programs. Choose a goal that is both relevant *and* attainable. Instead of planning that condom availability will reduce the rate of spread of HIV among the adolescent population over the next five years, plan to increase the acceptance of condoms within your community or the number of adolescents who have access to HIV prevention education and skills development.

State objectives clearly and include aspects that are measurable. For each objective, ask: "What does this objective really address and how will we know when it is fulfilled?" The answers form the building blocks of an evaluation; they suggest both what should be measured and what type of method is appropriate.

A. Process Objectives

Process objectives usually describe the number or duration of specific aspects of the program. Some examples are:

- Ten faculty or staff members will be recruited to counsel students about sexuality and condom use by October 15, 1993.
- Condoms will be available five days per week during the school year, including teacher work days, but excluding school holidays.
- All 9th-grade health curricula will cover proper condom use as part of the HIV prevention component, starting with the fall semester of the 1994-95 school year.

If the objective does not specify what should be measured, consider its purpose for helping to meet program goals, then re-work the objective so that it does specify what should be measured.

For process evaluation data, forms can be developed to record most of the information one will need. Simple forms can yield powerful process evaluations:

Timelines. Use planning calendars or charts that plot program activities by the week or month to compare the actual timing of activities to the original plan. Document events that constrain or facilitate the program. These stumbling blocks or windfalls will be important to others considering the process.

Daily Activities Logs. Logs are useful for collecting counts of students, condoms provided and types of counseling provided by individual school-based condom availability program staff. See Attachment B.1 for Philadelphia's log form, which illustrates one approach to collecting this type of information.

Field Notes and Reports. Field notes provide a convenient system for gathering information from individuals who are working directly with students. Keep them in diary format or develop forms to standardize the process. Keep forms in one file for easy access. Periodic reports on the progress of the program should be prepared, filed for reference and submitted to a supervisor. Field notes are also useful for gathering qualitative anecdotes about the program.

B. Impact Objectives

Impact objectives focus on the effect of program activities. These objectives should state what the program will do for or with the target population — in other words, the outcomes to be produced by the program. Examples are:

- All 9th-graders will be able to demonstrate proper condom use at the completion of the HIV prevention component of the health curriculum.
- Ninety-five percent of enrolled high school students will know three adults from whom they can request condoms, as of November 1, 1993.
- Twenty-five percent of the school population (which represents approximately 50 percent of the youth engaging in sexual intercourse in this school) will have requested condoms by June 15, 1995.

As the objectives are reviewed, make adjustments that enhance their usefulness for collecting information. A good objective will answer: "who, what, where, how, when and why."

V. DESIGNING THE EVALUATION STRATEGY

Evaluations should be part of program design, along with the development of implementation strategies.

A. Steps to Evaluation

The four steps for planning an evaluation include:

- deciding what to measure
- collecting information
- determining the meaning of the information obtained
- using that information to inform future decisions.

Step #1: Review Objectives; Decide What to Measure. The most critical step is creating the evaluation design. Without it, data are meaningless. Considerations for measuring the impact of a program may include: the number of students who use the program; numbers of condoms provided over a specific time period; condoms per user over time; changes in reported behavior; changes in knowledge, attitudes and values of the student population and, possibly, of the surrounding community.

Construct evaluation objectives based on the program activities. Use a who, what, when, where, why and how approach. Who is involved — which youth, which teachers or school staff, what outside groups? What is happening? When

do activities take place; where do they take place? Why are things happening or not happening? How are aspects of the program running? How are they viewed by key groups?

Step #2: Collecting information. There are two basic considerations after identifying the type of information to collect: how to get it and when to get it. It is important to collect data when an event or activity actually happens.

Samples

Collecting information from everyone within the program population is ideal. In most cases, however, there are too many individuals to reach. Samples provide a means for representing the population in a smaller group. Samples are usually drawn to reflect the same proportions of a set of population characteristics. Thus, if your parent population is 70 percent female and 30 percent male those percentages should be similar in your sample.

Several methods of selecting samples exist. In a **random** sample, all individuals in the population have the same chance of being selected. Choosing names of parents from a hat produces a random sample. Sometimes small subgroups are **over** sampled. This simply means that you select a greater proportion of a sub-group so that the responses can be analyzed more readily. Other samples are biased by the selection technique used. For example, a **convenience** sample consists of people who are at a particular location where you have access to them. Interviewing parents at a mall or grocery store is an example of convenience sampling. Because many people choose to shop at locations near their homes, the sample will be biased towards more local residents and against people from other areas of the community. Random sampling strategies can become very complex and require expert help. Many of the biased methods, however, can yield worthwhile information and should not be discounted.

Baseline Measures

A **baseline** is a measurement that is taken before the program or a specific program activity has begun. Baseline information is used to characterize what exists before the program begins. The key here is to gain a standard for comparison. The methods for gathering information described throughout this chapter apply to collecting baseline data as well as other kinds.

Again, use the identified objectives as a guide. If the objective is to teach all students the proper use of a condom, first determine if anyone within or related to the school system is providing the same information. If so, how many students are reached? Have they retained the information? Is the information acceptable to them as presented? How many students can already demonstrate that they know how to use a condom?

Baseline information is helpful in designing program process and impact evaluation strategies. If baseline data suggests that every student has this information, that fact can not be attributed to the introduction of the program and the objective should be adapted.

Comparison Groups

Just as baseline measures describe a population or situation at the program's outset, comparison groups allow tracking of changes due to the program versus those due to changes in the social milieu. Comparison groups are made up of individuals who are similar to the target population but are not exposed to the program. Select comparison groups using the same criteria as used for the target population: age, grade level or school. While no two groups are identical, the goal is to try to minimize differences. Randomly dividing all

classes into groups and providing sexuality information to only one group allows the researcher to compare groups in order to ascertain the effectiveness of the sexuality curriculum. If different teachers provide this information to the different groups, however, it may be more difficult to judge whether the curriculum, the teacher or other factors affected the students' sexuality knowledge. CPO strongly advises you obtain assistance when adding a comparison group study to your evaluation to insure that the right comparison group is chosen and the appropriate study design is used.

Methods of Data Collection

Evaluators commonly refer to quantitative and qualitative data. Quantitative methods include tests, surveys and written questionnaires. These methods are most useful when evaluation questions ask how much, how many or to what extent. Qualitative methods immerse the observer in the subjects' situation to gain a better understanding of how and why they think, feel and behave as they do. There are benefits and limitations to both approaches.

Qualitative approaches are biased by the viewpoint of the observer; they are most often used with individuals and small groups to assess whether programs are on the right track or to solicit concerns for future surveys. They allow one to formulate appropriate questions or approaches and field notes that address perceived concerns. Focus groups and observation are examples of qualitative methods.

Quantitative approaches can gather large amounts of information from various segments of the population. Due to the cost and complexity of quantitative methods, one needs to be fairly certain of the breadth of information that already exists in order to feel confident that what is investigated is important to program objectives. Surveys and counts are examples of quantitative methods of gathering data.

These two approaches can complement each other. Most program evaluations include both qualitative and quantitative methods. Both are useful in process and impact evaluation.

Collecting information need not be burdensome if the appropriate systems are planned ahead of time. Have tools or systems prepared and appropriate individuals designated to collect and store information.

The method used for collecting data is determined by the type of information desired. If one wants to collect data from a large numbers of respondents, a survey is a very effective method. Surveys, interviews and focus groups can be used to gather information from a small population or from representative samples of a larger population. Focus groups can be used even when the participants cannot be selected randomly so that they represent all segments of the population. Focus groups are particularly useful in identifying the range of attitudes and beliefs that exist in a population before a broad investigation is conducted.

To ascertain that specific skills have been learned, observation is an excellent technique, but must usually be limited to small numbers because it is very time-consuming. Knowledge can also be examined in larger groups using survey techniques.

Step #3: Analyze the Collected Information. Data analysis provides a summary of the information gathered, illustrating the overall picture and allowing for comparisons of data from different groups within the target population.

Process measurements can often be assessed by comparing expectations and actual program activities. Compare field notes with the program plan and record any changes in the plan and the reasons for those changes. Pay particular attention to the outcome of the training exercises, the conclusions of group discussions – anything that will help improve the program and continue program activities. Ways to present data include summarizing participation or use of service figures and noting growth or attrition among the number of participants. Comparing timelines, work plans and budget projections to the actual dates, sequence of events or expenditures is also helpful.

Analyzing the effect or use of a program often involves statistical approaches. Wherever possible, simple forms of analysis, such as counts or percentages, are best. For example, count the number of condoms provided each month of the program or track the percentage of males versus females who request condoms.

These measures can be divided into groups based on the characteristics of your population (gender, grade level, race, etc.). This allows for ease of interpretation and use of summary findings. Also, simple measures are easier for existing staff to collect, analyze and maintain. For more complicated analyses, most programs will need the help of a trained evaluator.

Step #4: Apply the Information to Modify Activities. Data are only useful when used. The evaluation information can be used in a variety of ways. Evaluation is important to funders and supporters, because it demonstrates the results of their investment and reinforces the importance of the program. Evaluation is also important for the community, where the results can attract increased support. Most importantly, evaluation guides program development. The information gathered through the evaluation process enables one to both monitor the programs' strengths and weaknesses and visualize ways to improve or redirect program efforts.

Results can also be developed into articles, reports, publications and press releases to increase community awareness, not only of the importance of condoms in preventing the spread of HIV, but also of adolescent reproductive health issues. Evaluation results that never get used are a waste of time, money and effort. Make your evaluation simple, attainable and usable.

Process evaluation can help redirect the program in midstream. Do not wait until the program has been completed to find out that all of the planned components were not implemented. Review the original plan as the program develops to discover how close it is to the actual implementation and to determine what should be done about discrepancies. Changes in the original plan can have a positive effect, especially if that change is responsive to needs that may have been overlooked or unnoticed in the original plan.

The summary information from the analysis will help program planners redesign aspects of the program to be more effective. This involves reassessing program plans. If one of the program's goals was to reach youth with limited access to condoms, and it instead attracted teens who were already using condoms, planners must consider alternative ways of reaching the targeted audience. Research results may lead to changing various aspects of the program.

The impact of a program cannot be measured until several years after the program begins. An impact evaluation should examine whether the program implementation plan has reached the target population as outlined by the program objectives. Specifically, have pregnancy or STD rates in your commu-

nity gone down, showed a slower rate of increase than at the baseline and so on? Is there improvement in other health indicators? Are more students delaying the age at which they have intercourse? Are more students using a condom at first intercourse? At every intercourse? Are they using it correctly? Of course, other effects may be seen and should not be ignored.

VI. GETTING HELP WITH EVALUATION

There are numerous reasons for getting help with evaluation plans. A professional evaluator can draft a plan, review plans for oversights and inconsistencies, help design a survey, select samples and analyze collected data. Program staff who are untrained in evaluation need help understanding each step of the process before beginning to plan the evaluation. Funding sources often ask grantees to conduct a more precise evaluation than they are capable of doing. Rigorous evaluations require money, time and thoughtful preparation with the expert help of a trained evaluator. Whatever the research needs, help is available if one knows where to look.

A. Written Materials

There are a variety of books on evaluation. Many organizations and individuals have developed step-by-step guides to designing evaluations. A few are listed in Chapter 9 of this guide. A vast number of textbooks are also available. The local college or university library or social sciences, psychology, education and public health departments can provide resources. People who conduct applied research in the social sciences as well as funding institutions frequently have simple written materials to guide evaluation planning.

B. Technical Assistance

If outside experience is needed in evaluation, help might be found at a local college or university. The social sciences, psychology, education and public health departments can provide information about whether a professor or student can help with the project. The kind of help available will vary greatly, but one can increase the chances of getting help by asking early in the planning process. Often, graduate students, eager for real experience, will work for fees much lower than those charged by professional evaluators. Sometimes one can arrange to let the student use the data for a thesis or a dissertation in exchange for the evaluation work.

In addition, there are a number of organizations that may be able to help with different aspects of the evaluation. Local youth-serving agencies and public health organizations may provide leads within the community.

Whether working with a graduate student or a seasoned professional, preparation will help communicate needs clearly and gain the best results. The process should be started in the early stages of program development. At the minimum, contact should be made three months in advance of when the first stages of evaluation will begin if one is looking for anything more than cursory assistance.

Be clear about the kind of help sought. If there is a plan in development, perhaps all that is needed is someone to critique it and be available for informal consultation three or four times during the evaluation process. If one needs help in designing the questionnaire, calculating the sample size and analyzing data, that needs to be clearly articulated. The evaluator will want to know how much time the project will take and whether or not he or she will be paid.

If the planning committee is unclear about the steps – and therefore the time required – have a full discussion of what is sought from the evaluation at the initial meeting. If planners are vague, and tasks keep getting added, volunteers may feel compelled to withdraw from their commitment; paid consultants will need additional funding beyond their initial cost estimates (and probably outside budget projections). Finally, help should be acknowledged often and publicly, as a regular part of reporting to funders, the community and agencies involved.

CPO offers training and technical assistance to groups implementing their programs. Staff at CPO can answer questions about the evaluation process and help in developing evaluation plans.

CHAPTER FIVE ATTACHMENTS

A. Proposed Evaluation Plan, New York City Schools

B. Sample Service Logs

   1. Philadelphia

   2. New York City

C. School Self-Assessment Survey, New York City

Proposed Evaluation Plan, New York City

I. EXECUTIVE SUMMARY

The growing incidence of HIV infection and AIDS among urban adolescents and young adults has led many observers to recognize that millions of adolescents are at risk of HIV infection and that dramatic initiatives are needed to prevent a sharp rise in the numbers of adolescents already infected with HIV. While many community-based organizations and social service agencies have begun integrating AIDS prevention messages into their work with youth, and while young people have been targeted through several mass media campaigns, additional interventions are needed to meet this challenge.

In response, the New York City Board of Education passed School Chancellor Joseph P. Fernandez's Expanded HIV/AIDS Initiative, a program to enhance education on HIV/AIDS in grades K-12, and to make condoms available to adolescents in all of New York City's 120 high schools and 10 high school programs. This initiative is the largest single AIDS prevention program for young people in the United States, and will serve as a model for several schools systems considering making condoms available within their schools as well. As such, this program needs to be rigorously evaluated for its success in helping young people to reduce their risk of HIV infection.

More specifically, an evaluation is needed to document the process of implementing the program in urban high schools and to examine its impact on the school's social environment, students' risk behavior, and communications with others on AIDS, drugs, sexuality and condoms. Because the program has created intense political controversy, a critical component of the evaluation is to document how these debates influence program implementation. It will also examine whether additional resources contribute to more successful outcomes.

The Academy for Educational Development, a nonprofit organization with more than 10 years of experience in helping schools to implement and evaluate educational reform, in conjunction with the Hunter College Center on AIDS, Drugs and Community Health and the Health Studies Department of New York University have developed a comprehensive evaluation design to assist policy makers, schools officials, public health officials and others in answering important questions about this initiative. A consortium of these three organizations will carry out the evaluation.

The evaluation seeks to answer the following eight questions:

1. Impact on Risk Behavior. Does a school-based HIV/AIDS education program which includes condom availability("the Program") lead to changes in sexual and drug behavior of students?

2. Impact on Communication. Does the Program lead to changes in patterns of communication about sexuality, AIDS, drugs, and condoms between students and their peers, sexual partners, teachers, parents and other adults?

3. School Climate. Does the Program contribute to changes in the school's social environment and normative attitudes related to AIDS, drugs, sexuality and condoms?

4. Program Intensity. Do different levels of program intensity lead to different outcomes in students' risk behavior, patterns of communication or in the school environment?

5. Impact on Different Groups of Students. Does the Program differentially engage or have a different impact on various groups of students(e.g., age, gender race/ethnic group or level of risk behavior)?

Summarized by The Academy for Educational Development, reprinted with permission.

6. Impact on Different Types of Schools. Does the Program have a different impact in different school settings (e.g., academic, vocational or alternative schools)?

7. Political Influence. How does political, administrative, parental, community or faculty support for or opposition to the program influence its implementation?

8. Wedge for Other Concerns. Does the program serve as a wedge for students to raise other concerns about health and sexuality in the school?

To answer these questions, the consortium will carry out the activities, summarized below:

1. Three cross-sectional surveys of a random sample of classes of New York City high school students in three age groups from a stratified convenience sample of twelve New York City high schools.

2. Two cross-sectional surveys of parents of students from twelve New York City high schools

3. Three cross-sectional surveys of a matched comparison sample from 12 schools in another city that is demographically similar but has only an AIDS education program and no condom availability plan.

4. Qualitative data collection (focus groups, observations, interviews) in twelve New York City schools and twelve comparison city schools to document the implementation of the program and the reaction to it.

5. A comparison of the quantitative and qualitative data in two New York City schools that are offered an intensive intervention designed by the evaluation team and two matched New York City schools that receive only the standard intervention.

6. Three annual surveys of all teachers and staff who interact with students in the twelve New York City schools.

7. Longitudinal data on the number of condoms distributed each month in each of the twelve New York City schools.

An overview of these research activities is presented in Table 1, and Table 2 summarizes how the methods described above will be used to answer the research questions.

To ensure that the results of this evaluation are widely disseminated, the researchers will prepare newsletters, for school officials and policy makers in New York and other cities; interim reports for the New York City school system; an evaluation manual for school staff involved in AIDS prevention programs; a handbook on lessons learned from the New York City experience and articles for professional journals.

Table 2
Summary of Research Questions and Major Methods

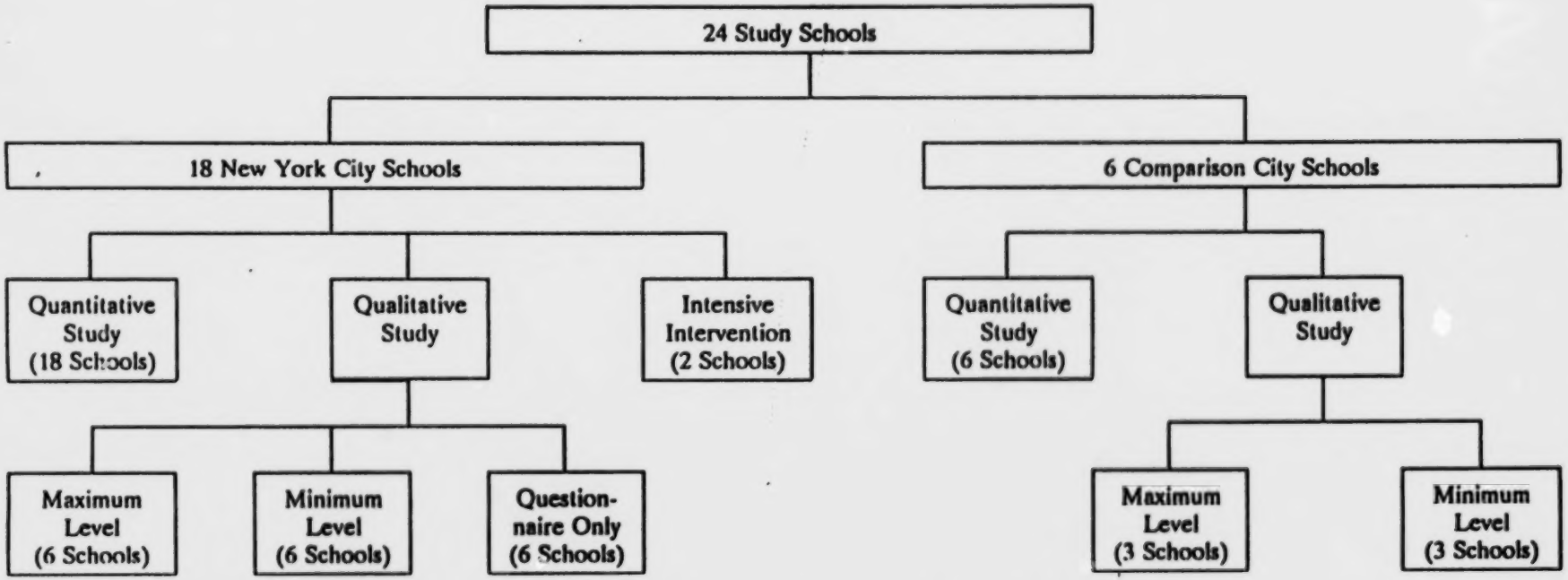
Method / Question	Surveys	Focus Groups	In-depth Interviews	Observations	Intercept Interviews	Existing School Data
Impact on risk behavior	1*	1*			1	8
Impact on communication	1*, 2, 3*, 4	1*, 2, 3, 4		1*, 3, 7	1	
Impact on school climate	1*, 3*, 4	1*, 2, 3, 4	5*, 6, 7	1*, 2, 3*, 4, 5, 6, 7	1	8
Impact of program intensity	1*, 3*, 4	1, 2, 3, 4	5*, 6, 7	1*, 2, 3*, 4, 5, 6, 7	1	8
Impact on different groups of students	1, 2, 3, 4	1, 2, 3, 4	5, 6, 7	1, 3, 4, 5, 7	1	8
Impact on different types of schools	1, 2, 3, 4	1, 2, 3, 4	5, 6, 7	1, 3, 4, 5, 7	1	8
Impact of political controversy	1, 2, 3, 4	1*, 2, 3, 4	5, 6, 7	1, 3, 4, 5, 7	1	8
Wedge for other concerns	1*, 2, 3, 4	1*, 2, 3, 4	5*, 6, 7	1, 3, 4, 5, 7	1	

Code: Numbers indicate population for which method will be used.

1=students, 2=parents, 3=teachers, 4=other school staff, 5=school administration, 6=AIDS team, 7=other groups or events, 8=reports on condom distribution

* indicates data will also be collected in comparison city schools.

Table 1: Overview of Research Activities



CPO 1993--ATTACHMENT V.B.1

Sample Service Log, Philadelphia

School Drop-in Resource Center
Service Log Sheet

Sheet: #_____ of # _____

Center: _____ ☐☐

Date: ____/____/____
mo day yr

Staff: _____ Total Hours: _____

										EDUCATIONAL & COUNSELING ISSUES										REFERRALS MADE						
LOG SHEET NUMBER	AGE		GRADE		SEX M	F	VISIT I	R	CONDOMS PROVIDED	ABSTINENCE	STD/HIV	FP/PREG	GEN HL	MENTAL HL	SCHOOL	FAMILY	DRUGS	GAY	OTHER	SCHOOL	STD/HIV	FP/PREG	GEN HL	MENTAL HL	CRISIS	OTHER
1																										
2																										
n																										
4																										
5																										
6																										
7																										
8																										
9																										
10																										
11																										
12																										
13																										
14																										
15																										
LOG SHEET TOTAL																										

Other Codes: (1) Relationships, (2) Rape, (3) Physical Abuse, (4) Intercouse, (5) Suicide, (6) Periods
* Code (/) if condoms provided, code "D" if condoms are denied by parental request.

Family Planning Council, Philadelphia, PA. Reprinted with permission.

SCHOOL DROP-IN RESOURCE CENTER
SERVICE LOG SHEET
CODE SHEET FOR SERVLOG.SYS

VARIABLE: DESCRIPTION AND CODING

CENTER: Two-digit code.

DATE: (YRMODA) Date on log sheet.

SHEET: Sheet Number from log sheet.

LOGNUM: Log Sheet Number.

AGE: Age of student: Enter age as recorded on log sheet.

GRADE: Student's grade: Enter grade as recorded on log sheet.

SEX: "1" if male
"2" if female
"9" if N/A

VISIT: if an "I" is recorded, enter "1" for INITIAL VISIT
if an "R" is recorded, enter "2" for RETURN VISIT

CONDOMS: "Condoms Provided"
if checked, enter "1" for YES
if not checked, enter "2" for NO
if a "D" is recorded, enter "3" for DENIED BY PARENTS
if an "R" is recorded, enter "4" for STUDENT REFUSED

EDUCATIONAL & COUNSELING ISSUES

For these variables, the coding is as follows:

if checked, enter "1" for ISSUE DISCUSSED
if not checked, enter "2" for ISSUE NOT DISCUSSED

ABSTIN: Abstinence

STDHIV: STD/HIV

FPPREG: FP/PREG: Family Planning/Pregnancy

GENHL: GEN/HL: General Health

MENTAL: MENTAL HL: Mental Health

SCHOOL: SCHOOL

FAMILY: FAMILY

DRUGS: DRUGS: Drug/Alcohol

GAY: GAY: Homosexuality

RELAT: Relationships

RAPE: Rape

PHYSAB: Physical Abuse

INTER: Intercourse

SUICIDE: Suicide

PERIOD: Periods

OTHER: Other

REFERRALS MADE

For these variables, the coding is as follows:

if checked, enter "1" for REFERRAL MADE
if not checked, enter "2" for REFERRAL NOT MADE

RSCHOOL: SCHOOL: School Referral

RSTDHIV: STD/HIV: STD/HIV Referral

RPREG: FP/PREG: Family Planning/Pregnancy Referral

RGENHL: GENHL: General Health Referral

RMENTAL: MENTAL HL: Mental Health Referral

RCRISIS: CRISIS: Crisis Referral

RDRUGS: Drug and Alcohol Referral

RLEGAL: Legal Referral

RDHS: DHS Referral

RJOB: Employment Referral

ROTHER1: Other Referral

ROTHER2: Other Referral

CPO 1993--ATTACHMENT V.B.2

Sample Service Log, New York City

NEW YORK CITY PUBLIC SCHOOLS

JOSEPH A. FERNANDEZ
CHANCELLOR

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MEMORANDUM

April 22, 1992

TO: HIGH SCHOOL PRINCIPALS, HIV/AIDS EDUCATION TEAMS, COMPREHENSIVE HEALTH COORDINATORS, TECHNICAL ASSISTANCE STAFF, and SUPERINTENDENTS' LIAISONS

FROM: John Schoener
Chief Administrator, Office of Research and Evaluation

SUBJECT: HIV/AIDS Team Self-Assessment Instruments: Health Resource Encounter Log and Monthly Encounter Report

The purpose of this memo is to explain the Health Resource Encouter Log and the Monthly Encounter Report. These instruments were designed by the Office of Research, Evaluation, and Assessment (OREA) in response to requests by schools for instruments that would be helpful for their self-assessments.

The encounter instruments are designed to help teams collect basic information about students' access to condoms, information, and counseling at school. These data will provide insight into the effectiveness of particular strategies used by schools such as site location and hours of availability. Specific questions that can be answered with the data collected on these form are listed below.

The Office of Research, Evaluation, and Assessment will aggregate monthly reports and send the information back to schools. At the end of the year OREA will send you a more detailed analysis relating number of encounters to the identifying information (e.g., gender of health resource volunteer, position, and time of day).

Completion of these encounter forms is voluntary. However, we strongly encourage your school to use these or similar forms, and send copies of the Monthly Encounter Report to OREA and the Superintendent's Liaison. The information, which will be aggregated by OREA and returned to your school, can be beneficial to your program as part of your self-assessment activities. Most importantly, the information you collect can facilitate future program planning and policy decisions at the school and program levels.

Encounter forms have been designed to protect student confidentiality. The forms ask for information on encounters, not students. Consequently, no student names or other identifiers should be written on these forms. In addition, the forms should be completed after students have left the room to lessen concerns about breach of privacy and to maintain the levels of trust essential to the program.

Following is an explanation of how the data you collect can be used and instructions for completing the instruments.

WHY COLLECT INFORMATION ON STUDENT ENCOUNTERS?

With the information collected on the Health Resource Encounter Log and summarized on the Monthly Encounter Report you will be able to answer the following basic questions about the Expanded HIV/AIDS Education Program in your school:

- How many student encounters are there each month? Does the number of encounters change over time as the program matures, or in response to external factors such as Magic Johnson's announcement of HIV positivity, or school factors such as changes in leadership? This provides insight into the influence of internal and external factors on student behavior.
- How many encounters are made by boys; how many by girls? Is there a relationship between the gender of the health resource volunteer and the gender of students who seek their help? This can help an HIV/AIDS team determine the schedule and staffing of health resource sites.
- What number and percentage of encounters are for condoms only? What number and percentage of encounters involve information or counseling only? What number and percentage of encounters involve information/counseling in conjunction with student requests for condoms?
- Do factors such as the time of day, day of the week, the location, or characteristics of the health resource volunteer affect the number of encounters?
- What are the students' concerns? What type of information or services are students requesting? This will help the team plan for additional training and identify resource needs.
- Are there issues that arise during these encounters requiring the attention of HIV/AIDS education teams, CHCs, principal, or the central administration?

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Answers to these questions will yield important information for a school's own program assessment and planning process. This information is also essential for the assessment of the initiative overall. For example, findings that 90 percent of encounters occur before school hours might prompt reconsideration of the mandate concerning the number of class periods that health resource staff should be made available during the day.

Information from schools will also help the central Office of Health identify follow-up training and technical assistance needs.

WHO SHOULD COMPLETE THESE INSTRUMENTS?

The Health Resource Encounter Log and Monthly Encounter Report should be completed by each health resource volunteer. To protect student confidentiality, only health resource staff members should have access to individual encounter logs.

HOW ARE THESE FORMS COMPLETED?

Specific instructions for each instrument are available. The include a sample of a completed Encounter Log and Monthly Summary Report.

WHEN SHOULD THESE INSTRUMENTS BE COMPLETED?

Ideally, information about a student encounter should be entered on the Health Resource Encounter Log after the student leaves the room. It may not always be possible to record information about the encounter right away; for example, another student may request your attention. Nevertheless, try to record the encounters as soon as possible, and to the best of your recollection.

Monthly Encounter Reports should be: 1) completed during the first few days of the next month, 2) collected by the HIV/AIDS Team Leader or designee, and 3) mailed to OREA by the 10th of the month. If, for example, there are 15 health resource volunteers in your school, 15 Monthly Encounter Reports should be sent to OREA each month. (See the address below.)

WHERE SHOULD THESE INSTRUMENTS BE SENT?

Monthly Encounter Reports for each health resource volunteer should be collected in the school and sent as a batch to:

Lori Mei, Ph.D.
Office of Research, Evaluation, and Assessment
New York City Board of Education
110 Livingston Street, Room 740
Brooklyn, NY 11201

Be sure to keep copies at your school for your own self-assessment activities and in case they get lost in the mail!

The HIV/AIDS team in each school should identify a safe place to store the Health Resource Encounter Logs. They are not needed by OREA because the information they contain is summarized on the Monthly Encounter Reports.

Expanded HIV/AIDS Education Program/Including Condom Availability

HEALTH RESOURCE ENCOUNTER LOG - INSTRUCTIONS

Information collected on the Health Resource Encounter Log will help schools assess the effectiveness of using health resource volunteers to make information and/or condoms available to students.

Each health resource volunteer on your HIV/AIDS team should make entries on the log every day that they volunteer in this capacity. If there are 23 or fewer encounters per month, only one log form will be needed. For more than 23 encounters use more log forms.

Student privacy must be protected. Please do not write student names or other identifying information on the log. Complete entries when students have left the room.

The following is a sample of a portion of a completed log. A complete blank form is also provided.

- Completing the "Questions and Comments" column is optional. This space has been provided for the convenience of health resource volunteers. Uses might include keeping track of student questions or as a reminder about needed follow-up.
- At the end of the calendar month, add the checks in each column and place the total on the bottom row of the form. If more than one page is needed for the month, place the grand total on the last row of the last page.
- At the end of each month, summarize information from the log on the Monthly Encounter report. Turn in these reports to the designated person on your HIV/AIDS Team.

If you have questions about this form, contact Linda Simkin or Peggy Lane at (718) 935-3772.

HEALTH RESOURCE ENCOUNTER LOG

Month: May

Name of School: Hudson River High School

Health Resource Volunteer: Mark Richards

Sex: M ✓ F ___ Title: Guidance Counselor

Date	Time of Day*	M	F	Check if condoms were provided	Check if information or counseling was provided	Questions or Comments
5/2	B.S	✓		✓	✓	asked about herpes virus
5/7	P.M.		✓	✓		
" "	L		✓	✓	✓	
TOTAL	—	1	2	3	2	—

*Time of Day codes: BS-Before School; AM-morning; L-students's lunch; PM-afternoon; and AS-After School

- Each line of the Health Resource Encounter Log relates to a single student encounter or interaction occurring during the time that you are acting in the capacity of health resource volunteer.
- Complete the "Time of Day" column by using the suggested codes or the exact time of day.

Expanded HIV/AIDS Education Program/Including Condom Availability

HEALTH RESOURCE ENCOUNTER LOG

Month: _____

Name of School: _____

Health Resource Volunteer: _____

Sex: M _____ F _____ Title: _____

Date	Time of Day*	M	F	Check if condoms were provided	Check if information or coun-seling was provided	Questions or Comments
TOTAL						

* Time of Day codes: BS=Before School; AM=morning; L=student's lunch; PM=afternoon; and AS=After School

MONTHLY ENCOUNTER REPORT - INSTRUCTIONS

This form is to be used by the health resource volunteer to summarize the information on the Health Resource Encounter Log each month. The form asks the volunteer to compute information separately for males and females; to indicate the types of information or assistance requested by students; and to note any occurrence relevant to policies and procedures that should be brought to the attention of the team or administration.

Each health resource volunteer should complete a monthly encounter form during the first few days of the next month and submit it to the HIV/AIDS team leader.

The following is a portion of a sample Monthly Encounter Report. A blank form which indicates the summary statistics section and three questions follows.

MONTHLY ENCOUNTER REPORT

Month: May

Name of School: High School of Evaluation

Health Resource Volunteer: Amelia Lang

Sex: M ____ F ✓ Title: Phys Ed.

1. Summary Statistics

	MALES	FEMALES	TOTAL
NUMBER OF STUDENT ENCOUNTERS	30	45	75
Number of encounters for condoms, only	5	10	15
Number of encounters for information or counseling, only	15	20	35
Number of encounters for condoms and information or counseling	10	15	25

- Please note that you are being asked to indicate the number of student encounters rather than the number of individual students served. If one student was seen on five different occasions during the month, five encounters should be recorded and counted.
- Question 2. Indicate how many encounters occurred in the listed categories.
- Question 3. Place a check next to the categories of information or assistance requested by students while you were functioning as a health resource volunteer.
- Question 4. Describe any situation or issue raised during student encounters that you wish to bring to the attention of the HIV/AIDS team, school administration, CHC, central administration, or other group.
- By the 10th of each month, schools should send a Monthly Encounter Report from each health resource volunteer to:

Dr. Lori Mei
NYC Board of Education
Office of Research, Evaluation, and Assessment
110 Livingston Street, Room 740
Brooklyn, NY 11201.

If you have any questions about this form, contact Linda Simkin or Peggy Lane at (718) 935-3772.

Expanded HIV/AIDS Education Program Including Condom Availability

MONTHLY ENCOUNTER REPORT

Month: _____

Name of School: _____

Health Resource Volunteer: _____

Sex: M _____ F _____ Title: _____

1. Summary Statistics

	MALES	FEMALES	TOTAL
NUMBER OF STUDENT ENCOUNTERS			
Number of encounters for condoms, only			
Number of encounters for information or counseling, only			
Number of encounters for condoms and information or counseling			

2. How many encounters occurred this month:

a. before school	_____
b. in the morning	_____
c. during student's lunch	_____
d. in the afternoon	_____
e. after school	_____
f. unknown	_____
Total Number of Encounters	_____

3. During this month, what types of information or assistance were requested by students? (Check all that apply.)

_____ a. abstinence
_____ b. information about HIV infection or AIDS
_____ c. proper use of condoms
_____ d. communication with sexual partner
_____ e. communication with parents
_____ f. communication with peers
_____ g. sexuality
_____ h. family issues
_____ i. death, dying, & bereavement
_____ j. HIV/AIDS testing
_____ k. pregnancy
_____ l. sexually transmissible diseases
_____ m. birth control
_____ n. sexual orientation
_____ o. school issues
_____ p. brochures/materials on health
_____ q. other personal health concerns
r. other _____

4. Please describe any situation or issue raised during the month that you think needs to be addressed by your HIV/AIDS Education Team, CHC, school or central administration, or other group. (Use the back of this paper if needed.)

CPO 1993--ATTACHMENT V.C

NEW YORK CITY PUBLIC SCHOOLS

JOSEPH A. FERNANDEZ
CHANCELLOR

HIGH SCHOOL MEMORANDUM NO. 103

May 22, 1992

TO: HIGH SCHOOL SUPERINTENDENTS
HIGH SCHOOL PRINCIPALS

FROM: Carmen Varela-Russo
Chief Executive

SUBJECT: HIV/AIDS Team Self-Assessment Survey

As you know, the HIV/AIDS Education Team in each school is required to assess its own HIV/AIDS Education Program. The purpose of this assessment is to have each school set its own objectives, measure how its program is operating, and identify successful strategies as well as ways to strengthen the program.

In response to requests by schools for guidance in conducting self-assessments, the Office of Research, Evaluation, and Assessment (OREA) has developed the attached survey instrument. Covering all major aspects of the Expanded HIV/AIDS Education Program, this instrument complements the information schools may be collecting with the Health Resource Encounter Log and Monthly Encounter Report that was recently disseminated to HIV/AIDS teams.

Designed in consultation with program staff, Technical Assistance staff, Comprehensive Health Coordinators, Superintendents' Liaisons, and school staff, the Self-Assessment Survey instrument can help schools review their HIV/AIDS Program activities and plan for next year. These questions can help schools assess their strengths and lead to constructive problem-solving where weaknesses are identified. In addition, completion of this survey will provide important historical program documentation. Such information can be extremely useful to have on file for a new school administrator or new members of an HIV/AIDS team.

The survey questions have also been designed to assist OREA's efforts to document the program and assess its implementation during the 1991-92 school year.

DIVISION OF HIGH SCHOOLS • 110 LIVINGSTON STREET • BROOKLYN, NEW YORK 11201

I am requesting your assistance in ensuring that schools undertake some meaningful self-assessment activity for the 1991-92 school year. Although schools are not required to submit self-assessment findings to the Office of Research, Evaluation, and Assessment, these findings would greatly assist our efforts to document and assess the program overall.

If you have any questions about this matter, please contact John Schoener, Chief Administrator, Office of Research and Evaluation, at (718) 935-3763.

c: Argie Johnson
Vincent Giordano
Francine Goldstein
Georganne Del Canto
Larry Edwards
Jill F. Blair
John DeMelio
Barbara Whitney
Robin Willner
John E. Schoener
Robert Tobias

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SELF-ASSESSMENT SURVEY

1. GENERAL ISSUES

1.1 What were your major accomplishments this year in implementing the Expanded HIV/AIDS Education Program Including Condom Availability?

1.2 What are the major obstacles to the success of the program? How can these obstacles be addressed?

1.3 To what degree is the Expanded HIV/AIDS Education Program coordinated with other school-based programs such as drug and alcohol prevention, attendance improvement/dropout prevention, health services, and pregnancy prevention? What factors have facilitated or impeded coordination?

1.4 What, if any, community-based organizations (e.g. youth programs, settlement houses, medical schools, colleges, social service organizations) were involved in your program? What is your assessment of the involvement of these organizations? Have you encountered any barriers to involving outside organizations in your program? If so, how were they or can they be addressed?

1.5 What activities, if any, were conducted or planned to reach students who are at highest risk for HIV infection? How successful were they?

1.6 What special programs and/or activities (e.g., peer education, theater productions, health fairs) has your school conducted to increase awareness about HIV/AIDS? How effective were they?

1.7 Has there been visible community support or opposition to the program? If yes, what form has it taken? What has been the impact on your program?

1.8 Did your school apply for a B.A.S.E. (Be Active in Self-Education) Grant? If not, why not? If yes, was the B.A.S.E. Grant helpful in supporting your program objectives? How was the team involved in the B.A.S.E. grant?

2. HIV/AIDS EDUCATION TEAM

2.1 What activities are conducted by your HIV/AIDS Education Team?

2.2 How often does the team meet? Is this frequency sufficient to accomplish your objectives?

2.3 What factors have facilitated your team's work to date? What factors have impeded it?

2.4 How has your team attempted to build cohesiveness, trust, expertise, or effectiveness? What "team building" methods have been effective?

2.5 Are any groups unrepresented or underrepresented on your team (e.g., teachers, administrators, parents, students, CBOs)? If so, what strategies might increase representation of these groups?

2.6 Does the composition of your team reflect the composition of your school in terms of race, ethnicity, and gender? If not, has this compromised the effectiveness of your team? If the composition of your team is a problem, what can be done to address this problem?

2.7 What provision, if any, has your school made to offer on-going HIV/AIDS training to staff, students, and parents?

2.8 What is the role of parent members on the HIV/AIDS team? Is the level of parent involvement on the team sufficient? How can parent involvement on the team be enhanced?

2.9 What is the role of students on the team? Is the level of student involvement on the team sufficient? How can student involvement on the team be enhanced?

2.10 What factors may have an impact on team composition for next year? How can you plan for any anticipated changes?

2.11 What ideas do you have to improve the functioning of your team?

3. CURRICULUM

3.1 How are the 6 required HIV/AIDS lessons taught in your school? (For example, are lessons taught in subject classes, gymnasiums, or assemblies? What were the strengths and weaknesses of your school's approach?

3.2 Who teaches the lessons? For example, are lessons taught by your own faculty/staff or professionals from the community? What percentage of classes were taught by school faculty or staff; what percentage by outside resources such as community-based organization (CBO) staff or health professionals.

3.3 Were HIV/AIDS curriculum materials available in the languages you needed? Were you able to obtain adequate supplemental resources such as videos or printed materials?

3.4 Were HIV/AIDS lessons delivered in subject areas (such as health education, science, social studies) ? What was your school's experience with regard to integrating the lessons into these subject areas?

3.5 What training or preparation did your teachers receive this year with regard to the HIV/AIDS curriculum? Is additional training needed? If yes, what type and for whom?

3.6 Were any special provisions made for teaching HIV/AIDS lessons to students who may be particularly difficult to reach (e.g. over-the-counter students, those with limited English proficiency, special education students, or chronic absentees)? If yes, what were they and were they effective?

3.7 Do you have any additional ideas for improving HIV/AIDS instruction in your school?

4. HEALTH RESOURCE ROOM AND CONDOM AVAILABILITY

4.1 How did you inform students about where and when condoms would be available (e.g. posters, PA announcements, brochures, explanations about what goes on in the health resource room)? Were some methods more effective than others? Why?

4.2 When and where are condoms made available to students? Do students seem to prefer obtaining condoms at a particular time of day or location?

4.3 How many Health Resource staff (volunteer staff who make condoms available) do you have? How many are male, how many female? Are Health Resource staff similar to your student population in terms of race and ethnicity? How does their gender, race, ethnicity, or sexual orientation affect students' comfort in asking for condoms?

4.4 How comfortable and knowledgeable are the Health Resource staff in counseling, responding to student questions, and making condoms available to students? What can be done to support Health Resource staff in their roles?

4.5 What factors appear to influence student requests for condoms?

4.6 What, if any, issues, situations, or questions were the Health Resource Staff unprepared to handle either directly or though referral? What can be done to address these concerns?

4.7 What information and materials are available in your health resource site?

4.8 What barriers have you encountered to setting up health resource sites? What additional resources or materials would be helpful?

4.9 What system have your established for ordering condoms and distributing them to health resource staff? How has this worked?

4.10 How have you ensured the safety of condoms? What, if any, problems have been encountered with storage? How were they addressed?

4.11 what does your team see as the most important outcomes of the condom availability aspect of the HIV/AIDS program?

5. PARENT INVOLVEMENT

5.1 What special activities were conducted in your school to acquaint parents with the Expanded HIV/AIDS Education Program Including Condom Availability? Who sponsored these activities? What were the strengths and weaknesses of these special activities?

5.2 Are parents kept sufficiently informed about the HIV/AIDS team's activities? How can team communication with parents be improved?

5.3 What factors have facilitated or impeded parent involvement in the HIV/AIDS program? How can parent involvement be enhanced?

5.4 Is there parental opposition to the Expanded HIV/AIDS Education Program in your school? What have been the most effective ways to handle such opposition?

5.5 Is there active, visible parental support? How has this support been developed or utilized?

CHAPTER SIX

LEGAL ISSUES

"Legal issues" often become the focus of significant attention when a community considers implementing a condom availability program in the schools. Although attention to these issues is important, the primary focus should always remain on the reasons for initiating the program and the program's goals. Specifically, a community should first decide the reasons for initiating a program, identify the program's context and goals and select the preferred approach for implementing a program.

Once the approach to implementing a program has been selected, consult with legal counsel to determine whether there is legal support for – or legal impediments to – that approach. Laws governing condom availability as a component of HIV/AIDS education may differ significantly from laws governing condom availability as a health service. If legal obstacles exist, it will be necessary to modify the approach or seek changes in the law.

While numerous legal issues might be of concern in specific communities, several issues frequently concern school boards and community advocates. These include:

- liability for condom failure
- sexuality education and/or HIV prevention mandates
- consent requirements
- liability for encouraging sexual activity of minors.

These issues must be understood in the context of the rights and obligations of three distinct groups: the school board, parents and adolescents.

I. BACKGROUND

Some local school boards and administrators may resist condom availability programs because of concern about liability and other legal issues. This hesitancy is understandable because schools need to maintain the goodwill of the communities they serve. The risk of bad publicity and the financial and human resources required to defend against any legal challenge should not be taken lightly.

Nevertheless, while schools must exercise caution to comply with legal and procedural requirements, fear of legal action should not deter schools from discussing, developing or implementing a policy to make condoms available. In fact, state and federal law may offer significant support for the school board, school administrator or youth-serving agency initiating an HIV/AIDS or pregnancy prevention program that makes condoms available on a voluntary basis to teens who engage in sexual intercourse.

Threats of court action are sometimes used to intimidate school officials into abandoning or not even considering a plan to make condoms available. On this or any other issue, an inventive attorney can usually find a plausible legal claim for a willing client. However, a distinction must be made between lawsuits that harass and intimidate and those that might prevail in court.

It is also important to remember that a lawsuit, or the threat of a lawsuit, does not represent community consensus. It often reflects the view of a small minority and may have little legal merit. This fact should not be obscured by the tone, fervor and publicity afforded legal challenges. In fact, no legal challenge to date has blocked implementation of a condom availability program.

Legal research early in the process can help communities avoid mistakes, respond quickly to threatened challenges and frame the public debate. It will also reveal any legal requirements or limitations that affect the design of the program. School condom availability – except in the context of school-based health centers – is a new phenomenon. Almost no case law exists dealing with this specific issue, and relatively few schools have fully explored the legal issues. Nevertheless, a number of consistent themes have emerged. These are discussed briefly below.

What follows is not intended and should not be understood to constitute legal advice. The Center for Population Options' (CPO) goal is to describe in lay terms the range of legal concerns that have been raised with regard to condom availability in schools. Any school or community group considering condom availability in the school setting should work closely with an attorney. Nonprofit organizations or coalitions can usually identify an attorney willing to provide *pro bono* (free) or low-cost legal services. School boards and administrators will usually rely on the advice of the school district's legal counsel.

II. SCHOOLS, PARENTS AND ADOLESCENTS

A. School Board Authority

School board or administrative authority is governed primarily by state law. Although states differ in the extent of control they delegate, local school boards are generally given broad authority to conduct activities or programs and expend funds to meet the needs of their students. Increasingly, states are encouraging "school-based management" as a strategy for improving the quality of solutions to local school problems, such as rates of teen pregnancy and sexually transmitted diseases (STDs). Furthermore, public schools historically have played a role in providing health services and education as a public health strategy. Many states require and provide funding for school nurses, health screening and prevention services, as well as health education programs. Health education and health services are already considered integral to school activities in many states.

A condom availability program would generally, unless otherwise prohibited by law, be considered a policy choice a school board is authorized to make. To meet any concerns about its authority to conduct a condom availability program, a school board should adopt policy that, at minimum:

- makes clear reference to the purpose for which it is adopted
- incorporates a series of findings and, whenever possible, statistics that document the compelling need for the program
- describes how condom availability addresses that need.

As of this writing, some states have laws that explicitly limit or prohibit making condoms available in schools. Several states, including Louisiana, Michigan and South Carolina, prohibit the distribution of contraceptive drugs or devices on school grounds. Other states restrict or prohibit a particular method of distribution, such as through school health centers or vending machines. Arkansas has prohibited the use of state funds to make condoms or other contraceptives available in schools, although the use of federal and local funds is not similarly restricted. It is essential that an attorney research state laws for the particular state in which a program is being considered.

School board policy and procedures are understood to have the force of law. If they conflict either with the constitution or with state statutes, they may be subject to legal challenge. Advocates may wish to consider challenging policies they believe endanger the public health or violate other laws. (For example, see "*Knowledge v. Board of Education of the City of New York*" in Section IV.B.)

In addition, decisions made without complying with official procedures or in violation of existing policies may also be challenged. For this reason it is important that school boards and health departments pay particular attention to their decision-making process and how decisions about condom availability affect, or are affected by, existing local policy.

B. *Parents' Rights*

Parents have long-recognized and constitutionally protected interests in the education and upbringing of their children. United States Supreme Court precedents dating back nearly three-quarters of a century recognize parents' rights to control their children's education and to inculcate religious values. These principles are expressed in a variety of ways in the school setting. They are not, however, without limits. For example, courts have found that parents who object to sex education courses on religious grounds are entitled, at most, to withhold their own children from participation and may not prevent the classes from being provided to other students.

Lawsuits challenging condom availability programs have included claims based on parents' constitutional right of family privacy, their religious rights under the First Amendment and the Due Process and Equal Protection provisions of the Fourteenth Amendment. Factors that may limit the scope of parental rights with respect to condom availability programs include:

- the compelling state interest in preventing the spread of STDs including HIV
- the voluntary non-coercive nature of the programs
- the school's encouragement of parental participation in overall AIDS prevention activities. (See Section IV.A for a brief description of the decision of the New York State Supreme Court in *Alfonso v. Fernandez*.)

C. *Adolescents' Rights*

Condoms are legally available to adolescents. The United States Constitution and several state constitutions provide protection for the privacy rights of minors. Moreover, adolescents have a legal right in most states to give their own consent for a range of health services, including contraceptive services (discussed below in Section III.D on "Consent").

Three United States Supreme Court cases – *Griswold v. Connecticut* (1965), *Eisenstadt v. Baird* (1972), and *Carey v. Population Services International* (1977) – affirm the constitutional right of all people, including minors, to purchase and use contraception.

In 1977, the Supreme Court ruled in *Carey v. Population Services International* that a New York law banning the sale of over-the-counter contraceptives to minors under age 16 was unconstitutional. The decision affirmed that minors have a constitutional right to obtain contraception based on the right of privacy. In addition, at least one federal court has ruled that a blanket requirement of parental notification when minors obtain contraception would be unconstitutional.[1]

While the Supreme Court has never ruled on whether parental consent or notification may be required for family planning services, the Court has ruled that if a state requires parental consent or notification when minors choose abortion, an alternative procedure such as a "judicial bypass" must be available to enable mature minors to make the decision on their own. Although this approach has not been tested in the context of access to contraceptive services, in its 1992 decision in *Planned Parenthood of South Eastern Pennsylvania v. Casey*, the Supreme Court distinguished between the weightier potential state interest in the minors' abortion decision and the implicitly weaker state interest in their "decision to use a nonhazardous contraceptive."

III. LEGAL ISSUES OF MOST FREQUENT CONCERN

A. Condom Failure and Product Liability

One of the first concerns raised by school officials is whether the school could incur liability if a student using a condom obtained in the school program were to become pregnant or infected with HIV or another STD. The likelihood that the school board, school district or school staff would be held liable in these circumstances is extremely slight for several reasons.

First, user error rather than product failure is much more likely to be the reason when pregnancy or infection occur despite condom use. Second, written instructions for proper condom use, and warnings that no contraceptive is 100 percent effective, are provided on the condom package to inform the consumer and protect the condom manufacturer from liability claims. Claims would have to be decided on a case-by-case basis. In any event, it would be extremely difficult to "meet the burden of proof" against the school (i.e. to prove that the action of school board or staff actually caused the pregnancy or infection).

There is no guarantee that claims of liability will not be filed against the school board or staff. However, CPO knows of no lawsuit making this claim against family planning clinics, health agencies or other public entities that have distributed millions of condoms free of charge.

The likelihood that the school board will be held liable is remote and can be reduced further by taking the following steps:

- Adopt written protocols for counseling and referrals. (This helps ensure that the counseling provided at the school and referral agencies is appropriate to the needs of the student and the skill of the staff or volunteer counselor and is consistent with program parameters.)
- Provide training and supervision for staff and volunteers. (This helps ensure a level of knowledge and proficiency and adherence to protocols on the part of staff or volunteers.)
- Provide written manufacturer's instructions and warnings with the condoms. (This ensures the student is informed of the correct way to use a condom and the risk associated with using it.)

B. Mandates for Sexuality Education, HIV/AIDS Prevention or Comprehensive Health Education

As of 1992, 38 states and territories required some form of HIV education in the school, either through legislation or regulation or rule adopted by the state board of education. An even larger number, 42, required health education. Of

these, 28 required that the health education be "comprehensive." At least 19 states and one territory have specified that the proper use of condoms should be included as one topic of instruction.[2]

These policies may address general content, hours of instruction, required or prohibited topics, curriculum, qualifications of instructors and parents' right to review materials and opt their children out of the program. When condom availability is conceived as a component of comprehensive HIV/AIDS prevention or health education, the program as a whole, not necessarily each component of the program, such as condom availability, must meet the requirements.

C. Health Services in the Schools

School-Based Health Centers. When condom availability is part of a public health initiative to address the threat of HIV/AIDS or teen pregnancy that is conducted with the cooperation of the school but not *by* the school itself, the authority is also rooted in the purpose of the cooperating health agency. Increasingly, states are encouraging the provision of primary health services in the schools through support of school-based health centers or cooperative relationships between the school and community health centers or public health departments.

School-based health centers are governed by laws regulating medical malpractice and liability, parental and informed consent, minors' right to consent to their own care in certain circumstances and the confidentiality of medical records, among others. When a health center already exists, it is usually a simple matter to begin making condoms available — unless either state law or school board policy prohibits making condoms or other contraceptives available. The contractual arrangement between the school and health agency that defines their relationship and operating policies may or may not have to be changed to permit condom availability. (See Chapter 8.)

Use of Licensed Professionals. Some schools, hoping to minimize the school's liability, have chosen the public health model for their program and have considered a policy that condoms can only be given out by licensed health care professionals. Since the service is not invasive and does not involve prescriptions, such a policy would not appear to be required by law, particularly if the program is supervised by a licensed health professional or agency. Requiring that health professionals be the ones to distribute condoms significantly increases costs of the program.

D. Consent

The question of consent for participation in a condom availability program is perhaps the most sensitive issue, both legally and politically. Involving parents in a manner that supports the goals of the program is highly desirable. As a matter of policy, schools will want to demonstrate their respect for parents' roles in the education and upbringing of their children, without undermining the integrity or effectiveness of the program. The school's legal obligation with regard to consent requirements is less clear, however. The competing constitutional claims of parents and adolescents have been described briefly above and must be considered in evaluating consent requirements.

Some advocates urge school boards to adopt policies that require either parental consent, parental notification or an opt-out provision enabling parents to indicate that their children may not participate in the program. There is no legal precedent establishing that consent, notification or opt-out is required —

or even permitted – for a condom availability program, although a number of states have adopted the opt-out approach for HIV prevention curricula or sex education classes.

There is some basis for concluding that parental consent, notification or opt-out provisions might be prohibited if a condom availability program were established based on a medical model and using public health staff. State laws generally permit minors to consent to their own health care when parental notice or consent requirements might deter them from seeking services:

- No state requires parental consent or notification for treatment of minors for sexually transmitted diseases (STDs).
- Twenty-four states explicitly affirm minors' access to contraceptive services, and no state law explicitly requires parental consent or notification, outside the general consent requirements for medical care.
- Courts in Florida and California have recently ruled that their state constitutions guarantee minors' right to privacy and have overruled statutes requiring parental consent for a minor's abortion. Similar statutes affecting contraception might also be found invalid.

In addition, as previously mentioned, at least one federal court has ruled that a blanket parental notification requirement for minors seeking contraceptives would be unconstitutional, and another federal court has ruled that parents do not have an affirmative constitutional right to be notified when their minor children obtain contraceptives on a voluntary basis.[3]

However, because condoms and other non-prescription contraceptives are available to adolescents in a variety of other settings, parental consent or opt-out provisions might be **permitted as a policy choice** by the school board. If a board adopted a consent or opt-out provision, it would have a legal obligation to enforce it. The provision might also be challenged by adolescents asserting their own right to privacy. While it is difficult to predict the outcome of such a challenge, at least some courts would be likely to support the school board's decision. On the other hand, if a school board were to decide, as a matter of policy, not to impose a parental consent or opt-out provision, strong legal support exists for such a choice. (See "Summary of *Alfonso v. Fernandez*," in Section IV.A.)

E. Criminal Liability

A number of individuals have expressed concern that in states where sexual intercourse with or between minors is illegal, schools or personnel providing condoms to sexually active students might be charged with aiding and abetting a crime or contributing to the delinquency of a minor. The risk of this occurring is extremely slight for several reasons:

- the universal lack of enforcement of these laws in cases of consensual sexual intercourse
- the experience of health providers who have been providing contraceptives to adolescents for decades (the Title X federal family planning program is specifically aimed at providing contraceptive services to low-income women and adolescents)
- the difficulty in proving knowledge and intent to aid in a crime on the part of the person who hands out the condom.

Schools can demonstrate that the program has a clear intent which is other than to encourage sexual activity on the part of minors by:

- explicitly addressing, in the stated goals of the program, pregnancy and/or disease prevention among students who are already sexually active
- providing training to school or other personnel who interact with students
- incorporating abstinence information and skills training into a sexuality or HIV/AIDS prevention curriculum.

IV. PENDING CASES ON CONDOM AVAILABILITY

Only a small number of cases have actually been filed challenging condom availability programs in the schools. These cases have been filed in New York, Massachusetts, Philadelphia and Seattle. So far only one case, *Alfonso v. Fernandez* in New York, has been decided by the courts.

A. Alfonso v. Fernandez

In November 1991, two parents of New York City public school students and Michael Petrides, a member of the board of education, filed suit against New York City Schools Chancellor Joseph Fernandez and the board of education, claiming that the condom availability program in public high schools violates public health law requiring parental consent for health services and medical treatment. They also claimed the program violates their right to free exercise of their religion and their due process rights.

They sought a court order "1) declaring the plan to be a health service, 2) enjoining the implementation of the program unless the minors' parents have consented, 3) requiring parental consent for the plan ... and 4) declaring the implementation of the plan to be a violation of the parents' constitutional and civil rights."

In its April 1992 ruling, the New York Supreme Court rejected all claims.[4] In New York, the Supreme Court is the trial court, the Appellate Division is the intermediate appellate court and the Court of Appeals is the highest state court. Plaintiff filed an appeal and oral arguments were held in January, 1993.

The court found that "[i]t is not without significance that condoms are not regulated in the same manner as prescription drugs; they need not be dispensed by a licensed pharmacist and are available for sale even in delicatessens." It concluded, therefore, that the condom availability program, while "health related, ... does not qualify as a 'health service' under Public Health Law Sec. 2504 and is not prohibited by that statute without parental consent."

With regard to the claim that the program violates parents' free exercise of religion under the First Amendment, the court found that "(a) viable First Amendment claim is not triggered by a voluntary school program which is neutral on its face and supported by a compelling state interest." The critical factor in the decision is the **voluntary, non-coercive** nature of the condom availability program. Religious freedom does not extend to the right not to be offended by beliefs or practices: "the possibility that the religious beliefs may be merely offended does not satisfy the requirement that those beliefs are unduly burdened ... Parents have no constitutional right to tailor public school programs to individual religious preferences."

Finally, in addressing the due process claims, the court affirmed the broad authority of the board of education to decide **matters of policy**. The court did not address whether a parental opt-out provision, if adopted as policy by the school board, would be constitutional. However, it did rule that **lack** of a parental opt-out procedure did **not** violate parents' due process rights to raise their children as they see fit. The ruling specifically cited the range of mechanisms – school-based planning teams, HIV/AIDS Advisory Council, providing information and suggestions about communicating about HIV, forums with parent groups, orientation meetings – by which the school encourages parent participation in the program and in their children's HIV education.

B. Knowledge v. Board of Education of the City of New York

Knowledge v. Board of Education of the City of New York was filed with the State Commissioner of Education by the New York Civil Liberties Union (NYCLU) to challenge a resolution adopted by the board. The resolution requires that all written and oral AIDS prevention instruction "devote substantially more time and attention to abstinence than to other methods of prevention." The resolution also bars any outside organization or individual from participating in "any aspect of New York Public Schools' AIDS education program" unless they have signed an agreement to comply with the resolution. The NYCLU claims the requirement conflicts with state regulations and law concerning other education goals and policies and violates faculty and student rights of academic freedom.

In October 1992, a hearing was held before New York's top education official, State Commissioner of Education Dr. Thomas Sobol, who is empowered to review all decisions by local school boards. On February 8, 1993, Dr. Sobol overturned the resolution, stating that the board overstepped its authority, infringed upon teachers' rights and "ventured beyond the realm of policy making into the realm of deciding how instruction should be carried out." Sobol struck down the resolution on two counts:

- In violation of state regulations, the board failed to consult its AIDS Advisory Council before approving the resolution.
- The resolution reaches beyond the board's legal authority to establish educational policy and approve curriculum, and "intrudes impermissibly upon the teacher's latitude to teach the curriculum in the most effective manner."

The New York City Board of Education's counsel recommended that this ruling be appealed in court, but no decision has been made as of publication date.

C. Curtis v. Falmouth School Committee

This case was filed in June 1992, in Massachusetts Superior Court. Plaintiffs, who are represented by the Rutherford Institute, seek an injunction against the Falmouth schools' condom availability program. The parents who are party to the suit allege violation of 1) the right of privacy to direct the education and upbringing of their children, 2) the liberty right in the nurture, education and well-being of their children, 3) the Free Exercise Clause of the First Amendment, 4) the Fourteenth Amendment Due Process and Equal Protection Clauses, 5) state criminal laws regarding sexual intercourse with or between minors and 6) state mandates for reporting suspected child sexual abuse. No hearing date has been scheduled.

V. LEGAL PRINCIPLES SUPPORTING CONDOM AVAILABILITY

While the body of law relevant to establishing condom availability programs in the schools is extensive and complex, support for such programs includes the following legal principles:

- To promote the health and well-being of students, school boards have broad authority to implement programs not specifically prohibited by law.
- Most states' laws would permit implementation of a condom availability program as part of either a health services, sexuality education, or HIV/AIDS prevention program.
- Parents have strong, constitutionally protected interests in the education and upbringing of their children, but these interests do not give them a clear right to prevent their children from obtaining condoms or to be notified when their children obtain them.
- Adolescents have a constitutionally protected right of privacy which protects their access to nonprescription contraceptives, including condoms.
- Minors have the right under the laws of most states to consent to health care for STD and pregnancy prevention.
- Condom manufacturers and third parties, including health care services providers, have not been held liable for pregnancy or STD infections resulting from condom failure.
- Providers of STD and pregnancy prevention services have not been held liable under criminal statutes prohibiting or controlling the sexual activity of adolescents.

Notes

[1]See *Planned Parenthood Association of Utah v. Matheson*, 582 F Supp. 1001 (D. Utah 1983); and *School-Based Health Clinics: Legal Issues*, (San Francisco and Washington, DC: National Center for Youth Law and The Center for Population Options, 1988), p. 15.

[2]Sex Information and Education Council of the U.S. *Future Directions: HIV/AIDS Education in the Nation's Schools* (New York: SIECUS, 1992) and the National Association of State Boards of Education and the Council of Chief State School Officers, *AIDS, HIV and School Health Education: State Policies and Programs* (Alexandria, VA and Washington, DC: NASBE and CCSSO, 1990).

[3]See *Doe v. Irwin*, 615 F. 2d 1162 (6th Cir. 1980), *Cert. Denied*, 449 U.S. 829 (1980); and *Planned Parenthood Association of Utah v. Matheson* 582 F Supp. 1001 (D Utah 1983); and *School-Based Health Clinics Legal Issues*, (San Francisco and Washington, DC: National Center for Youth Law and The Center for Population Options, 1988), p. 15.

[4]*Alfonso v. Fernandez*, New York Superior Court Co. Richmond, Index Number 8785/91, April 23, 1992.

CHAPTER SIX ATTACHMENTS

A. New York City Corporation Counsel Memo

B. Advisory Article: Washington State School Directors' Association

CPO 1993--ATTACHMENT VI.A

The City of New York

LAW DEPARTMENT
100 CHURCH STREET
NEW YORK, N. Y. 10007

VICTOR A. KOVNER
Corporation Counsel

Opinion No. 2-91

February 19, 1991

Board of Education of the City of New York
110 Livingston Street
Brooklyn, New York 11201

Dear Honorable Members of the Board of Education:

This is in response to your request on January 7, 1991, for an opinion regarding potential liability for the Board of Education that may arise from implementation of the proposed "Chancellor's Expanded HIV/AIDS Education Program Including Condom Availability" (the "Chancellor's Plan".)

Description of the Plan

The Plan would provide comprehensive education in the transmission and prevention of HIV/AIDS and would, as a complement to the classroom instruction, make condoms available to high school students who request them. The Chancellor's Plan was contained in a draft document dated January 4, 1991. We have had discussions with the Board and the Chancellor about the Plan and have recently reviewed the most recent revised draft of the Plan, dated February 8, 1991.

The key elements of the Plan include an expanded and revised curriculum on HIV/AIDS; a minimum number of HIV/AIDS lessons for each grade; monitoring of implementation and results; an advisory council on HIV/AIDS education in each school district; High School HIV/AIDS Education Teams; an educational brochure for high school students; review of coordination of Health Education programs; staff training; parental involvement in curriculum development and a condom availability policy for high school students.

The Chancellor's Plan would require each elementary school and high school to develop a school-based plan for improving HIV/AIDS education. A minimum of five lessons per grade, containing age-appropriate and accurate information about HIV/AIDS, would be required for grades K-6. Students in grades 7-12 would continue to receive a minimum of six lessons per grade on HIV/AIDS, as currently required under Chancellor's regulations.

A revised HIV/AIDS curriculum for all grades, K-6 and 7-12, will emphasize abstinence as the most effective way to avoid the

sexual transmission of the HIV/AIDS virus, encourage responsible decision-making and behavior, and provide information and instruction on the appropriate use of condoms as a barrier against the transmission of HIV/AIDS. Students in the high schools will receive an educational brochure relating available facts and resources on HIV and AIDS.

Each high school would also be required to develop a school-based plan to make condoms available to students upon request. Condoms would be made available at at least one identified location at each high school site by school faculty or non-employee volunteers. Students would not be required to obtain parental consent, nor would they be required to sign their names, or otherwise identify themselves, in order to receive a condom. Additionally, there would be no minimum age requirement for a high school student to obtain a condom.

The Chancellor's Plan proposes that in addition to volunteers from the school staff, volunteers from private or public health agencies may be assigned, through agreement with the agency, to make condoms available at the school sites under the supervision of the building principal.

The Plan also proposes that the persons who would be responsible for making the condoms available would offer counselling and guidance services if requested by a student. All persons who participate in the condom availability program would be required to participate in a training program on referral services and other relevant matters.

The Chancellor's Plan involves parents in a variety of ways: in the development of curriculum content, as members of high school HIV/AIDS Education Teams, in the development of school-based plans for improving HIV/AIDS education, as members of the advisory councils on HIV/AIDS in each school district and as members of the Chancellor's Advisory Council on HIV/AIDS. The Plan does not require parental consent prior to making a condom available. Your inquiry regarding the legal issues raised by the possibility of providing an opportunity for parents to opt-out or for a requirement of parental consent is discussed in the final section of this opinion.

Summary of Opinion

We have come to the following conclusions concerning the issues raised by the Board.

(1) The Board has the statutory power to adopt a plan that contains the elements of the Chancellor's Plan, including the provisions for condom availability.

(2) There is no realistic chance for any personal liability resulting for any member of the Board were the Board to adopt the Plan.

(3) The likelihood of any liability for the Board based on a claim of a defective condom or inadequate warning or instructions is remote. Other public and private agencies that have distributed numerous condoms show an almost total absence of any legal claims. There are some steps which the Board might take to reduce even this minimal potential for liability.

(4) The Board is empowered to use volunteers in this as in other programs. It is responsible for the actions of any authorized volunteers and thus should provide proper guidance and supervision.

(5) If the Board concluded as a matter of policy that some kind of parental role was desirable as part of a condom availability plan, it would appear to be constitutionally permissible to have a parental opt-out or a parental consent provision. However, we believe an opt-out provision is more likely to withstand judicial scrutiny, since it is likely to be viewed as providing a better balance between the rights of students, of parents and of the broader society. Plainly, there is no legal requirement to adopt either alternative as part of a condom availability plan.

We now discuss these matters in more detail.

1. The Board's Authority to Make Condoms Available Upon Request to High School Students

An initial question that has been raised is whether the Board has the legal authority to undertake the kind of condom availability program proposed in the Chancellor's Plan. We believe that it does.

State regulations provide broad powers to school boards to maintain the health of students as well as specific powers related to AIDS prevention instruction. In the former category, school boards must "provide and maintain a continuous satisfactory program of school health service" and "guide parents, children and teachers in procedures for preventing and correcting defects and diseases." 8 N.Y.C.R.R. §136.1(d) and §136.3(a)(1). In addition, school boards must "provide for adequate guidance to parents, children and teachers in procedures for preventing . . . diseases and in the general improvement of the health of school children." 8 N.Y.C.R.R. §136.3(a)(10). With respect to AIDS prevention instruction, state regulations provide that, while such instruction must stress abstinence, it must also provide "accurate information to pupils concerning the nature of the disease, methods of transmission, and methods of prevention . . . " 8 N.Y.C.R.R. §135.3(b)(2); (c)(2).

Although none of these broad regulations explicitly refer to the availability of condoms as part of a school board's health and AIDS education programs, they provide strong support for such actions. Furthermore, given the seriousness of the AIDS epidemic and the fact that an item that does not require a prescription (and is not medically invasive) can do so much to thwart the epidemic's growth, it is highly unlikely that a court faced with the question would find the Board of Education without the authority to make condoms available in conjunction with its AIDS prevention instruction program.

2. Personal Liability of Board Members

The Board has inquired whether its members shall be held personally liable if the Board were to adopt the Chancellor's Plan. Based on all the circumstances surrounding this matter, and the care and deliberation which the Board has demonstrated in regard to this issue, we believe the answer is clearly in the negative.

Section 2560, subdivision 1, of the Education Law provides that the members of the City school board (and its employees) shall be entitled to legal representation and to indemnification pursuant to the provisions of Section 50-k of the General Municipal Law. That section, which relates to civil actions brought against employees of the City of New York, provides essentially (subject to various procedural requirements) that representation and indemnification will be provided if the public employee was "acting within the scope of his public employment and in the discharge of his duties and was not in violation of any rule or regulation of his agency." The section has been interpreted to require a broad reading favorable to an employee who has been sued, (see, e.g., Blood v. Board of Education, 131 AD2d 128 (First. Dept. 1988).

The Board of Education is frequently called upon to make difficult decisions on controversial public issues, as in this case. One of the purposes of §2560, and comparable provisions in other laws, is to make sure that the Board is not deterred in carrying out its public responsibilities by threats of personal liability. If the Board decides to adopt the Chancellor's Plan, it is our view that it will be acting within the scope of its powers. The Board has acted responsibly in seeking the view of its lawyers on this and other aspects of the Chancellor's Plan. We have provided the Board with legal counsel through this opinion and in other discussions. The Board and its members are entitled to rely on this opinion in any policy decision they may wish to make and should be insulated from personal liability regardless of whether some court in the future may disagree with parts of the program.

3. Board Liability

The Board has asked whether it could be held liable if a claim were made that the condoms made available under the Plan were defective or that no instruction in proper usage was given.

In order for a claim against the Board based on a defective condom to be successful, a number of elements would have to be established. A court would have to find that the Board was a party legally responsible for the defect and, thus, a proper party to the lawsuit. There would also have to be proof of an injury and evidence that the defect in the condom caused the injury. The lack of any one of these elements would cause a claim based on either a defect or inadequate instruction to be dismissed. The difficulty of proving that the failure of a particular condom caused an injury, a pregnancy, or the transmission of a disease may be the reason that there are so few reported cases based on condom failure. Our research has revealed only one case. J.P.M. and B.M. v. Schmid Laboratories, 178 N.J. Super 122 (1981).

The absence of such reported cases seems consistent with the experience thus far of the City's Department of Health and other agencies and institutions which have distributed condoms. We are advised that since 1987 the Department has purchased more than ten million condoms (including more than four million in 1990) for distribution in various of its programs and through many outside organizations. The City's Health and Hospitals Corporation, which operates all the municipal hospitals, also distributes condoms through various programs and services. The Corporation Counsel's Office represents these and all other City agencies in all the lawsuits filed against them. We are not aware of a single lawsuit that has been filed in recent years against these agencies resulting from their distribution of condoms. Planned Parenthood has also distributed many condoms through various of its programs, and we are advised that its general counsel is not aware of a single action having been filed against that organization as a result of its condom distribution. Of course, even if there were claims and some recoveries, that would not make this program different from almost any other City or Board-run program. Injuries and some risk can occur even in the best-run and best-intentioned programs.

In Fiscal Year 1990, the City paid out $158 million in resolving over 3500 claims (the largest single payment involved the hospital system). The Board of Education paid out nearly $13 million in resolving 770 personal injury claims or legal actions last year brought by students, parents, employees and others. Claims for damages against the Board could and have resulted from programs involving physical education, student athletics, supervised playground activities and almost every other useful Board program. The appropriate policy question to be asked is whether a program serves a worthwhile purpose (without incurring substantial and inappropriate

risk of liability) and, if it does, how to minimize any risk that might arise.

Having said this, we now consider the possibility that a student may receive a defective condom made available under the Chancellor's Plan, or receive inadequate instruction, become pregnant or contract a disease as a result and bring suit against the Board. We, therefore, offer the following analysis and opinion regarding the theories and considerations that a court could take into account in addressing the claims that could be raised in such a lawsuit.

The Board's potential liability for injuries caused by a defective condom raises two legal issues:

First, would the Board of Education be considered a party responsible for the defect if defective condoms were made available under the Chancellor's Plan?

Second, even if the Board were not considered to be responsible for a defect, could it, nonetheless, be held liable for failing to warn of the risks associated with using condoms or for giving inadequate instruction in their use?

Claims for injuries caused by a defective consumer product are typically raised under the product liability theories of strict liability, breach of warranty or failure to warn of risks. The theory of strict liability holds a manufacturer, distributor or seller liable if the product is inherently defective or is made defective by either its design or manufacture. A claim of breach of warranty seeks to establish that the product was not suitable for its intended use.

In our view, the risk that liability would be imposed on the Board of Education would be minimal in the event a defective condom was made available to a student under the Chancellor's Plan.

(a) Inadequate Design or Manufacture

As to the question of who is legally responsible for a defective product, products liability theories assign liability to those parties who realize a commercial gain from distributing a product. New York case law recognizes that parties who are peripheral to the commercial chain of distribution should not be held liable. Persons who are so removed from the commercial distribution of a product that they can have no influence upon a manufacturer to alter a defective product have been held not to be accountable as defendants. Brumbaugh v. CEJJ, Inc., 152 AD2d 69 (3rd Dept., 1989); Blackburn v. Johnson Chemical, 128 Misc.2d 623 (Sup. Ct. Kings Cty. 1985). This rule which allows manufacturers, distributors and retailers to be held liable for defects is based upon a policy rationale of spreading the burden of compensation for the plaintiff's injuries among those best situated to correct the defects. Bickram v. Case I.H., 712 F.

Supp. 18 (E.D.N.Y.1989); Mead v. Warner-Pruyn, 57 AD2d 340 (3rd Dept. 1977).

Mead held that the seller, who markets his product for use and consumption, has undertaken and assumed a special responsibility toward any member of the public who may be injured by it. The court found that imposing strict liability on both the retailer and the manufacturer was justified because "they can adjust the costs of protection between them in the course of their continuing business relationship." (Mead, supra at 342.)

It is our understanding that the Board of Education will make condoms available to students free of charge and in the sealed packages provided by the manufacturer. Since it would not be in the business of marketing condoms, we believe that the Board of Education would be viewed, at most, as a non-commercial distributor and not as a retailer, as the law recognizes these terms and, therefore, would not be held accountable for defective condoms under the most commonly used theories, strict liability and breach of warranty.

(b) Inadequate Warning

A manufacturer, commercial distributor or retailer may be held liable for sale of a product made defective either by its design or manufacturer or by a failure to warn of risks associated with using the product. Under New York law, knowledge of the special risk of harm associated with the normal or foreseeable uses of a product imposes a duty to warn adequately of the risks. A failure to warn renders the product defective under theories of both warranty and strict products liability. Ezaqui v. Dow Chemical Corp., 598 F. 2d 727 (2d. Cir. 1979). Voss v. Black and Decker, 59 NY 2d 103, 107 (1983). The printed instructions and warnings that appear in and on packages of condoms are intended to insulate the manufacturer from liability for failure to provide such warnings.

Since the likelihood of inherent defects in condoms is minimal, a claim against the Board of Education might be based on a "failure to warn" theory. Since the Board would not be a commercial distributor, we do not believe it would be liable for failing to warn students of the risks associated with using condoms under a products liability theory.

The courts have, however, on occasion found non-commercial distributors liable under a theory of negligence when the manufacturer's warning has been removed from the product. Harris v. International Harvester Co., 128 Misc.2d. 623 (1984). Thus, if the Board were to remove, alter or otherwise fail to pass on to a student the manufacturer's warnings and instructions, the withholding of the information might constitute part of a negligence claim against the Board.

So long as the Board of Education makes condoms available with the printed instructions and warnings provided by the manufacturer, and does not contradict or alter this material, it would minimize the risk of liability under either a "failure to warn" theory of products liability or a theory of negligence.

Even if the Board of Education were to be considered a retailer and, thus, a proper party to a lawsuit, the liability for a defective product may be shifted to the manufacturer through a contractual agreement between the manufacturer and the Board to indemnify the Board of Education. We would advise the Board to require an indemnification provision in any purchase agreement with a supplier.

(c) Inadequate Instruction

Under the Chancellor's Plan, each high school would be required to identify members of the school staff, or non-employee volunteers who would be responsible for making condoms available and offering counselling and guidance services upon request. The rationale, expressed in the Plan, is that "[a]ccess to a trained adult on the school site provides an opportunity for students to discuss and understand their sexual behavior and ensures that students fully understand the appropriate use of the condom as well as the risks associated with its use."

These adults would be required to participate in a training program that would prepare them to provide instruction in the proper use of the condom, emphasizing available networks of referrals for HIV-related concerns, bereavement counselling and crisis intervention. Once trained, they would be supervised by the building principal.

On the whole, making counselling and guidance available upon request together with the condom makes good sense and will undoubtedly, in the long run, decrease rather than increase the chance that mistakes will occur. However, as with any such program, the undertaking of such counselling and guidance, though not otherwise required by law, may give rise in an occasional case to a legal claim of negligence for inadequate warning or inadequate instruction.

If the Board were to make condoms available free of charge, in pre-sealed packages with the manufacturer's unaltered instructions and warnings, and a student did not request counselling and guidance, the Board would not be liable for inadequate instruction.

If counselling and guidance were requested by the student, what instructions would be required and what standards of potential liability might be applied? Classroom instruction pursuant to state law is generally immune from tort liability. The courts have held boards of education not liable for "educational malpractice," such as

graduating a student with substandard capabilities, Donohue v. Copiague Union Free School District, 47 NY2d 440 (1979) and Hoffman v. Board of Education, 40 NY2d 121 (1979). Whether individual counselling requested by a student outside the classroom setting would be subject to the same immunity is not entirely clear. See, Florence v. Goldberg, 44 NY2d 189 (1978).

But whether such immunity would be conferred or whether a court may analogize the relationship more to that of a physician or health care provider and a patient, there are a number of useful steps which the teacher (or other volunteer) should take, e.g., to reiterate or refer the student to the warnings on the manufacturer's package; to give accurate and reasonably complete instructions on the proper use of the condom; to demonstrate a use of the condom on an anatomically representative, if not accurate, model; and to not contradict any of the warnings provided by the manufacturers. Of course, since under the Plan the student is not required to request or accept any counselling or guidance in order to receive a condom, the nature or amount of counselling that might be possible may vary with individual students.

The area of birth control has not been free of tort litigation. These cases have generally been limited to claims of medical malpractice for an improperly performed surgical procedure (tubal ligation in the female or vasectomy in the male, Sorkin v. Lee, 78 AD2d 180 (1980), Sala v. Tomlinson, 73 AD2d 724 (1979)), or the occasional incorrect prescription of birth control pills, Troppi v. Scarf, 187 N.W. 2d 511 (Mich. Ct.App. 1971). Were liability to be found by a court, there are various items of medical, economic or other damages which could flow from a student's use of a defective condom, which include unwanted pregnancy and transmission of the AIDS disease.

Although there is always a possibility of substantial damages in an individual case, we conclude that there is not a substantial risk of liability under a theory of negligence if the Board were to provide the counselling and guidance that could be requested by a student under the Chancellor's Plan. It is possible, nonetheless, despite a comprehensive and professionally designed training program, that instruction may be inadequate in some instances. The Board may limit the opportunities for inadequate or inaccurate instruction by training and monitoring the persons who will do the counselling and make the condoms available as provided by the Plan.

4. Role of Volunteers

The Board has also inquired whether it could be held liable on the ground that it had no authority to cede health instruction to volunteers, whether in the employ of the Board or not.

Schools have traditionally used the services of volunteers in various programs. There is no general prohibition on the use of volunteers; on the contrary, their use is generally recognized and, if anything, is encouraged. One indication of this can be found in the statutes (discussed previously) that deal with representation and indemnification of Board employees. The individuals entitled to such representation and indemnification in the New York City district (under Education Law §2560(1)) include, in addition to board members, teachers, supervisors and employees, an "authorized participant in the school volunteer program in such city." Moreover, the protection to be afforded such Board members, employees and authorized volunteers is that provided in Section 50-k of the General Municipal Law, which applies to civil actions against employees of the City of New York. In that section, "employee" is defined to include "a volunteer expressly authorized to participate in a city sponsored volunteer program."[1]

Thus, the Board may utilize the services of volunteers in implementing this program. Of course, the Board would be responsible for the consequences of the actions of any authorized volunteers in the same way as it would be for the actions of its own employees. Thus, as with any volunteer program, the Board must carefully define the role of the volunteer and provide appropriate guidance, training and supervision to the volunteer. This appears to be contemplated by the Chancellor's Plan, which provides (February 8 Revised Plan at p. 8) that the volunteers would be required to participate in a training program developed by central headquarters with the help of others, and that "once trained, these volunteers would be under the supervision of the building principal who would be held responsible for the implementation of the school's approved HIV/AIDS Education Plan."

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[1] In addition, it should be noted that the Legislature in 1982 added a provision that appears to recognize the useful role that volunteers can perform in the school context. Apparently, a practice had developed in some school districts of requiring those wishing to volunteer to first sign a waiver releasing the Board of Education of liability if the volunteer was injured in performance of authorized volunteer duties. Subdivision 2 of Section 2560 of the Education Law was enacted in 1982 and prohibits the board or a community school board from requiring a "volunteer participating in any school activities" from executing such a waiver. This was meant to preserve any existing rights regarding "the performance of authorized volunteer duties by an authorized participant in the school volunteer program." An accompanying legislative memorandum explained that "another benefit of this bill will be to induce more individuals to volunteer in schools . . . the schools will have the benefit of many additional volunteers to assist with school sponsored activities," 1982 N.Y. State Leg. Ann. 148.

5. Parental Role Through Opt-Out or Consent

As noted before, the Chancellor's Plan provides for parents to play a role in various parts of the overall program but it would not require parental approval in order for a student to obtain a condom. The Board has inquired about the legal implications of a parental role regarding the dispensing of condoms. Could the Board require parental consent prior to making a condom available? Could the Board recognize a parental role not by seeking approval as a pre-condition but by allowing those parents who affirmatively chose to do so to opt-out of the program? Of course, there is no legal requirement to include either alternative as part of the Plan. The following discussion analyzes the law in this and related areas.

In Carey v. Population Services International, 431 U.S. 678 (1977), the United States Supreme Court, among other things, invalidated a provision of the New York Education Law which prohibited any person from selling or distributing any contraceptive of any kind to a minor under the age of sixteen. Noting that the right to privacy in connection with decisions affecting procreation extended to minors as well as adults, the Supreme Court concluded that state restrictions inhibiting these rights would only be valid if they served a significant state interest. Id. at 693. Since neither a blanket prohibition nor a blanket requirement of parental consent could be imposed on a minor's choice to terminate her pregnancy, the court determined that "the constitutionality of a blanket prohibition of the distribution of contraceptives to minors [wa]s a fortiori foreclosed." Id. at 694.

The Court noted that the state's assertion that free availability of contraceptives would increase sexual activity among minors did not amount to some significant policy that would justify the burden the statute imposed on the exercise of minors' fundamental rights. Id. at 694-96. Furthermore, the fact that a physician could still supply patients with drugs he or she deemed proper did not save the statute. Rather, it merely "delegate[d] the State's authority to disapprove of minors' sexual behavior to physicians, who m[ight] exercise it arbitrarily, either to deny contraceptives to young people, or to undermine the State's policy of discouraging illicit early sexual behavior." Id. at 699.

The Supreme Court has been silent on the issue of minors and contraception since Carey. However, it has rendered decisions in the abortion context that lead us to conclude that while a parental consent requirement or parental opt-out provision in the Chancellor's Plan appear constitutionally permissible, the latter would probably be more likely to withstand judicial scrutiny.

First, the Court has clarified its position on parental consent requirements for minors seeking abortions. In Bellotti v. Baird, 443 U.S. 622 (1979), the Court determined that a parental consent requirement does not unconstitutionally burden a minor's

right to seek an abortion if the state also provides for an alternative procedure whereby authorization for the abortion can be obtained. Id. at 643. Thus, in the abortion context, an adequate judicial bypass procedure has become the litmus test for state-imposed parental consent requirements.[1]

Second, despite the Court's affirmance of a woman's right to choose to have an abortion, it has upheld prohibitions on providing direct funding and/or the use of public facilities and employees to effect the abortion decision. See, e.g., Webster v. Reproductive Health Services, ___ U.S. ___, 109 S. Ct. 3040, 3051-53 (1989) (state statutory ban on use of public employees and facilities for performance or assistance of nontherapeutic abortions did not violate Constitution); Harris v. McRae, 448 U.S. 297, 325, 100 S. Ct. 2671 (1980) (validated Hyde Amendment, which withholds from states federal funds under the Medicaid program to reimburse the cost of abortions except where mother's life is endangered); and Poelker v. Doe, 432 U.S. 519, 521, 97 S. Ct. 2391 (1977) (no constitutional violation where City of St. Louis decided to provide publicly financed hospital services for childbirth without providing corresponding services for nontherapeutic abortions). In all these instances, the woman choosing an abortion was seen to be left with other options, even if her indigency, coupled with these funding or facility limitations, would make it difficult, if not impossible, for her to terminate her pregnancy. See Webster, supra, 109 S. Ct. at 3052 ("Missouri's refusal to allow public employees to perform abortions in public hospitals leaves a pregnant woman with the same choices as if the State had chosen not to operate any public hospitals at all").

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[1] See also Planned Parenthood League v. Bellotti, 868 F.2d 459 (1st Cir. 1989) (upheld statute requiring consent of both parents or persuasion of a Superior Court justice that the minor was mature enough to make an informed decision or that the operation was in her best interest); Planned Parenthood v. Casey, 744 F. Supp. 1323 (E.D. Pa. 1990) (struck down informed parental consent provision -- which included a visitation requirement -- and determined that judicial bypass procedure did not eliminate the burden it imposed); and Planned Parenthood Ass'n v. McWherter, 718 F.Supp 1064 (M.D. Tenn. 1989), question certified, ___F.2d ___, 1991 W.L. 3450 (6th Cir. 1991) (two-parent consent requirement deemed unconstitutional on its face given its failure to account for the pregnant minor living in a single-parent home and the fact that burden was neither vitiated by a cumbersome judicial bypass procedure nor justified to further any legitimate state interests). Last term, the Supreme Court invalidated a two-parent notification requirement for a minor seeking an abortion in Hodgson v. Minnesota, ___ U.S. ___, 110 S. Ct. 2926 (1990).

It will appear from these cases that since the Board has no obligation to make condoms available and minors still have the opportunity to obtain condoms (freely or at minimal cost) from other sources without parental consent, it would be permissible for the Board to make parental consent a prerequisite to condom availability or to give parents the opportunity to exclude their children from the program.[3] On the other hand, what might be an acceptable limit on a minor's right to choose an abortion may not be applicable in the context of evaluating a minor's access to condoms.

In Bellotti, supra, the Supreme Court noted that the general rule making parental consultation desirable -- i.e., minors' lack of the "experience, perspective, and judgment to recognize and avoid choices that could be detrimental to them"[4] -- becomes particularly acute when considering "the profound moral and religious concerns" raised by the abortion decision:

> There can be little doubt that the State furthers a constitutionally permissible end by encouraging an unmarried pregnant minor to seek the help and advice of her parents in making the very important decision whether or not to bear a child.[5]

The special factors cited in support of parental involvement in the context of abortion do not apply to a condom availability plan. A decision to have an abortion is irrevocable and cannot be postponed.[6] Streng parental support often is required if the minor is interested in choosing other alternatives such as marriage to the father or the responsibilities of motherhood. Id. at 642-43. Given the medical, emotional and psychological consequences of an abortion, parents (involved through the consent process) are particularly equipped to provide important data to the physician as well as referrals to other sources of medical history. See H.L. v. Matheson, 450 U.S. 398, 411 (1980).

Lower courts that have addressed the question of parental consent in the context of contraceptive services for minors appear to support the conclusion that parental consent may be more vulnerable to judicial challenge. In Doe v. Pickett, 480 F. Supp. 1218 (S.D.W. Va. 1979), the district court concluded that the West Virginia Department of Health could not impose a parental consent requirement on federally-funded family planning services for minors since federal statutes (i.e., Title X of the Public Health Service Act and Titles IV, XIX, and XX of the Social Security Act) mandated that services be made available to eligible persons, including minors who do not obtain parental consent. The court also noted that such a policy could not be seen as promoting any justifiable state interest:

> The State has not asserted an interest which would warrant parental involvement which would interfere with the provision of contraceptive information, supplies, physician consultation, examination, counselling, or referral for appropriate medical procedure. It seems clear that such a requirement

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[3] This assumes that the condoms would be made available as part of an AIDS-prevention program and not under those circumstances where the State Legislature has authorized treatment without parental consent. See e.g., Public Health Law §§2305(2) and 2504(4) (parental consent not required for services by a physician in the event of an emergency or for the diagnosis or treatment of a sexually transmitted disease). Furthermore, if the condom plan was characterized as a medical or health service, the Public Health Law would prohibit a parental consent requirement for any student who is 18 or older or is a parent or has married. Public Health Law §2504(1). Thus, as to some mature or emancipated students, a requirement of parental consent may be prohibited. Finally, if the program were to involve the staff of facilities operated by the Department of Mental Hygiene or receiving state funds through that department, the Board should note that state regulations (8 N.Y.C.R.R. §27.6(3)) allow facility staff to distribute drugs or devices designed to regulate contraception to patients under 18 years of age who are not married or are not the parent of a child at the staff's discretion and provide that the staff "should consult with the patient's parent or legal guardian whenever practicable".

[4] 443 U.S. at 635.

[5] Id. at 640-41 (quoting Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 51, 91 (1976). See also id. at 103 (J. Stevens, concurring in part and dissenting in part) ("Whatever choice a pregnant young woman makes - to marry, to abort, to bear her child out of wedlock - the consequences of her decision may have a profound impact on her future life").

[6] See also T H v. Jones, 425 F. Supp. 873, 882 (D. Utah 1975), aff'd on statutory grounds only, 425 U.S. 986 (1976).

would hinder the early provision of these services.[7]

In Doe v. Irwin, 615 F. 2d 1162 (6th Cir), cert. denied, 449 U.S. 829 (1980), the Sixth Circuit determined that a publicly operated family planning center's practice of distributing contraceptives to unemancipated minors without notice to their parents did not infringe on the constitutional rights of parents.[8] While recognizing that three sets of rights were involved (those of parents, minors and the state), the court emphasized that the state had imposed no compulsory requirements or prohibitions infringing parents' constitutional rights and therefore that the court did not have to consider whether (a) a compelling state interest was involved or (b) parents' rights outweighed those of their minor children. Id. at 1168-69.

There are further reasons why a parental consent requirement may be considerably more vulnerable to constitutional challenge than an opt-out provision. The practical consequences of the two types of parental involvement are significant. A plan requiring parental consent (i.e., opting-in) is likely to have

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[7] Id. at 1223. Other cases invalidating the engrafting of consent requirements onto the provision of family planning services in the face of conflicting federal statutory law include Planned Parenthood Association v. Dandoy, 810 F.2d 984 (10th Cir. 1987)and Jane Does 1 through 4 v. State of Utah Department of Health, 776 F.2d 253 (10th Cir. 1985). See also State of New York v. Heckler, 719 F. 2d 1191 (2d Cir. 1983) and Planned Parenthood Federation v. Heckler, 712 F. 2d 650 (D. C. Cir. 1983). Both of these latter cases invalidated regulations promulgated by the Department of Health and Human Services that would have, inter alia, required parental notification within ten days after prescription contraceptive devices were distributed to their children. Despite Title X's language about encouraging family participation, the courts determined that Title X did not authorize a notification requirement. With respect to the proposed regulation that would have required compliance with state laws mandating parental notice or consent for the provision of family planning services, the Second Circuit reversed that portion of the district court's judgment invalidating and enjoining the regulation with instructions to dismiss so much of the complaint as had raised the claim. 719 F. 2d at 1197; see also Planned Parenthood Federation v. Heckler, supra, 712 F.2d at 663-64 (continuing policies of Title X prohibited agency regulation where state eligibility standards might conflict with the federal statutory scheme).

[8] Although the center also did not ask minors whether they had obtained parental consent prior to distributing contraceptives, this practice was not challenged by the parents. See 615 F.2d at 1163-64.

significantly fewer participants than one allowing opting-out. Many parents may simply not get around to signing such a consent form. The result may well be that such a requirement may prove to be a barrier that may significantly reduce the number of high school students who could otherwise have access to this program. This would be especially troubling if participation was significantly diminished in those areas where the highest incidence of AIDS is found. An opt-out provision, on the other hand, would exclude only those whose parents consciously made an effort to register their position. It would not inadvertently exclude many students.

While it is hard to predict the outcome of litigation, one should not underestimate the potential impact on a trial court of the specific facts and equities of the particular action. Faced with a challenge in an area which has some legal uncertainty, a court might well be far more disposed to uphold a plan which gave a role to parents but which did not result in substantially, and perhaps unnecessarily, reducing the number of students who could benefit from the program, especially if those excluded from the program lived in areas that indicated a greater need for participation. Thus, were the Board to decide as a matter of policy that parental involvement was appropriate, an opt-out provision has the potential of being viewed as providing a better balance between the rights of parents, of students and of the broader society.

Moreover, there are already statutory and regulatory precedents for an opt-out provision in certain situations. The Education Law provides that pupils may be excused from the study of health and hygiene if it conflicts with the religion of his or her parents or guardian. See N.Y. Education Law §3204(5) (McKinney 1981). The Regulations of the State Commissioner of Education provide that pupils are not required to receive instruction concerning the methods of prevention of AIDS if the parents have filed a written request that the pupils not participate in such instruction, with assurances that they will receive such instruction at home. 8 N.Y.C.R.R. §135.3(b)(2); (c)(2).

The latter regulations were the focus of the New York Court of Appeal's decision in Ware v. Valley Stream High School District, 75 N.Y. 2d 114 (1989). In Ware, parents who were members of the Plymouth Brethren had asked the school district to exempt their children from the entire AIDS curriculum. This request was denied on the grounds that the regulations did not authorize the local board to grant a complete exemption. However, the children were exempted from that portion of the curriculum labeled "Prevention," which consisted of five lessons on how abstinence from illegal intravenous drug use and sexual activity could prevent the transmission of AIDS. Id. at 118. The children were still required to attend lessons on "Practice skills in saying no," "Know ways the AIDS virus can and cannot be transmitted," and "Recognize and evaluate media messages regarding sexuality." Id. The parents sought exemption from the entire program on the grounds that it

violated their constitutional right to freely exercise their religion and their privacy right to rear their children.

The Court of Appeals concluded that the State had not made a showing with particularity that its interest in educating children regarding AIDS would be substantially impeded by granting an exemption to plaintiffs' children. Id. at 128-31. According to the state (whose compelling interest in sustaining the program amounted to controlling the spread of the AIDS disease), the possibility that some of the Plymouth Brethren might leave the fellowship or go astray posed enough of a public health threat to warrant burdening the plaintiffs' religious rights. Id. at 129. The Court of Appeals found no evidence either way as to such possible defections and also noted that a fuller record was necessary before a court could resolve the factual dispute as to whether or not plaintiffs' home education program constituted a "functional equivalent of the AIDS curriculum." Id. at 129-30. As a consequence, the lower courts' summary rejection of the plaintiffs' asserted constitutional rights had been inappropriate. Id. at 131. Ware thus demonstrates that even without an opt-out provision, school boards might still have to excuse children from participation in the Chancellor's Plan if faced with a challenge based on religious grounds.

You have also asked whether an opt-out provision is required under state regulations. As noted above, the Regulations of the Commissioner of Education provide for an opt-out provision from a part of the required AIDS curriculum. A regulation added in 1987 required all secondary schools to provide appropriate instruction concerning AIDS as part of required health education courses. Such instruction "shall be designed to provide accurate information to pupils concerning the nature of the disease, methods of transmission, and methods of prevention; shall stress abstinence as the most appropriate and effective premarital protection against AIDS, and shall be age appropriate and consistent with community values." 8 N.Y.C.R.R. §135.3(c)(2). As noted, the regulation allows a parent to opt-out of that part of the program "concerning the methods of prevention of AIDS." Id.

The Board has inquired whether this required opt-out provision would apply to the condom availability part of the Chancellor's Plan. We are advised that the Commissioner of Education has issued an opinion on this matter. In a brief memorandum to the Chancellor dated December 10, 1990, Commissioner of Education Thomas Sobol wrote that the "staff of Office of Counsel of the State Education Department have reviewed your plan for distributing condoms in certain schools in the New York City School District. We find no prohibition in State Law, Rule or Regulation against such a plan." We have ascertained that the Commissioner was commenting on an earlier draft of the Chancellor's Plan dated November 29, 1990. However, that draft provides for essentially the same plan in regard to condom availability as the later drafts dated January 4, 1991 and February 8, 1991.

Although the Commissioner's December 10 memorandum is brief, it concludes that the Chancellor's condom availability plan (with no provision for parental consent) is not prohibited by any provision of any State law or regulation. This presumably includes the Regulations of the Commissioner of Education, including the sections mentioned above. The interpretation by an administrative agency of its own regulations is accorded great weight and deference by the courts. An independent reading of that section of the Commissioner's regulation would lead to the same conclusion since the opting-out provision is expressly limited to a specified portion of the instructional program otherwise required of every student.

In conclusion, although we do not believe that parental opt-out from the condom availability plan is required by Section 135.3 of the Commissioner's Regulations, if the Board determines that some kind of parental role regarding condom availability is desirable as a matter of policy, we believe that an opt-out policy would be permissible and that it would be more likely to withstand judicial scrutiny than a parental consent requirement.

We understand that, as this program is considered further, the Board may have additional questions. We are ready to assist you as such issues arise.

Sincerely,

VICTOR A. KOVNER

cc: Chancellor Joseph A. Fernandez

Adivsory Article: Washington State School Directors' Association

Rutherford letter on condom distribution misleading

by Lorraine Wilson, Director, Policy and Legal Services, WSSDA

School board members in several districts have received a letter from the Rutherford Institute of Washington this fall discouraging boards from holding hearings on the option of distributing condoms to students. The concern with the letter is the tone and implication that boards are barred by state law from considering condom distribution programs; this is not true. It is and should remain a local decision whether or not to consider or adopt a condom distribution program in an individual school district.

Public input is legally necessary, politically wise and invaluable in making the right decision on a condom distribution program.

There is no legal prohibition against school districts considering a condom distribution program for students. Especially under the recent legislation that expanded school board powers, a school board may adopt any policies not in conflict with other law that promote the education of kindergarten through twelfth grade students in the public schools; or promote the effective, efficient or safe management and operation of the school district. Chapter 141, 1992 Laws of Washington, 301. It is up to each board whether or not a condom distribution program should be considered.

Usually, school districts that have considered or adopted such a program have worked with another agency which provides the condoms and counseling. The school district merely authorizes and oversees the program. Education funds are not used to support the program, instead the health service is made available to students under restrictions established by the school board.

The Rutherford Institute mentions several AIDS education laws in its argument that school districts should not hold public hearings on condom distribution programs. Those statutes do provide guidance and regulation for AIDS education and curricula, but they do not bar districts from considering or participating in a condom distribution program. These issues are separate and the Rutherford Institutes effort to confuse and combine the two should be resisted.

The AIDS education statute requires a dual approach: school districts are required to teach that abstinence from sexual activity is the only certain means of avoiding infection, and that there are risks to sexual intercourse with or without condoms and condoms and other artificial means of birth control are not a certain means of avoiding infection. See, RCW 28A.230.070, AIDS education in public schools. Excluding discussions about condoms and other contraceptives in AIDS education programs is not medically accurate nor legally sufficient.

Further, discussing and accepting public testimony regarding the pros and cons of a condom distribution program is not an educational activity subject to the curricular requirements of the AIDS education statute. It is the obligation of the board to provide a reasonable opportunity for public written and oral comment on policies before the board. The board cannot restrict the content of public comment so that it meets the medical accuracy test required of curricular materials about AIDS. If the board is considering a condom distribution program, unrestricted public input should be encouraged.

In short, school boards should not be intimidated out of considering condom distribution programs because of the Rutherford Institute letter. The AIDS education statute regulates curricular materials and requires that district programs affirmatively address the risks of condoms and other contraceptives. The AIDS education statute does not prohibit consideration of condom distribution programs by school boards.

If it is appropriate under local circumstances, boards should consider whether or not a condom distribution program is in the best interest of the students in the district. Public input is legally necessary, politically wise and invaluable in making the right decision of whether or not to have such a program.

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CHAPTER SEVEN

THREE CASE STUDIES

School districts and communities around the country have wrestled with the question of whether to make condoms available to high school students. Communities that have opted for condom availability programs vary in size and location. Program design also varies, reflecting each community's values and needs. This chapter presents case studies of three communities with condom availability programs: Adams County, Colorado and the cities of New York and Philadelphia. Each study includes a chronology of the important events related to HIV/AIDS prevention education and condom availability, a description of the program design and information on training, funding and evaluation.

The three programs highlighted have similarities and some important differences. All:

- Placed condom availability within a broad HIV/AIDS education program.
- Engaged experts from outside the school to help shape the plan.
- Included parents, students and faculty members in the program design.
- Did not use school-district funds to purchase condoms or staff the program.

On the other hand:

- New York has no parental opt-out for the program, whereas Adams County and Philadelphia do.
- School personnel staff the programs in Adams County (nurses and volunteer faculty) and in New York (staff and volunteer faculty), while in Philadelphia outside-agency health providers have that responsibility.
- Counseling is required in Adams County and Philadelphia before a student can receive condoms; in New York counseling is available, but not required.
- Philadelphia and New York require schools to establish sites where condoms are available; in Adams County, nurses provide condoms in their offices and faculty advisors carry "condom cases" and provide counseling wherever convenient.

In the face of the growing HIV/AIDS epidemic, these three school systems chose to include condom availability programs within existing prevention and education services for their students. Creativity and flexibility allowed each district to design a program to suit the community's needs.

I. ADAMS COUNTY, COLORADO

In September 1989, condoms were made available to students as part of the Disease Prevention Program at the two high schools located in Adams County, Colorado. Approved in August, 1988, Adams County's was probably the first district-wide condom availability program in the United States.

Adams County School District's two high schools have a combined student population of 1,500. Nearly 80 percent of the students reside in Commerce City, a town of 20,000 just outside Denver. Fifty-three percent of the students are white, 40 percent are Hispanic, three percent are Native American, three percent are African-American and one percent is Asian.

The chronology of Adams County's implementation demonstrates how critical it is to pay attention to timing. This school district deliberately delayed implementing its condom availability program for a year after it was approved in order to build community support and understanding.

A. Chronology

December 1987. Committee on AIDS Education, staffed by school district personnel, is formed to develop proactive policy in preparation for possibility of HIV-positive students or teachers in the school system.

April 1988. Colorado Department of Education invites Adams County School District to an AIDS Education for Youth Project regional training in San Francisco sponsored by the Centers for Disease Control and Prevention (CDC). School officials and staff attend the two-day training, returning to Colorado more comfortable with, and knowledgeable about, HIV/AIDS issues.

May 1988. Local health officials and providers conduct educational work session with the board of education to gain support for a district-wide policy on HIV/AIDS awareness training and universal precautions for handling body fluid spills. The superintendent directs the Committee on AIDS Education to develop a comprehensive HIV/AIDS policy that includes condom availability.

June 1988. The Committee on AIDS Education presents a draft policy to the board of education. Included in the document are recommendations for handling body fluids, processes for addressing the presence of HIV-positive students or staff and four education and prevention strategies: 1) increasing community knowledge, 2) promoting staff development, 3) developing curricula and 4) preventing disease transmission through condom availability.

July 1988. The board of education holds a public forum regarding adoption of policy. The hearing attracts a large number of community members and much media attention. Supporters of the policy make a strong showing, but the condom availability proposal is the focus of controversy. The opposition numbers about 40 individuals who appear to be affiliated with conservative religious groups.

August 1988. The board of education passes the draft policy by a three-to-two vote after the section regarding disease transmission is changed to offer a parental opt-out for both sexuality counseling and condom availability, as well as to specify that condoms can be made available only under the auspices of a licensed physician of either Commerce City Community Health Services or the Commerce City Family Health Center.

1988-1989 School Year. The Committee on AIDS Education focuses on community education, staff development and updating its curriculum. It presents several awareness activities to staff, parents and students.

September 1989. The condom availability program (termed "the disease transmission prevention program") is quietly implemented at the two Adams County high schools. School nurses provide counseling and condoms to 76 students during the 1989-90 school year (figures for repeat visitors are not available).

November 1990. Condom availability program personnel is expanded to include 22 trained volunteer faculty advisors.

1990-91 School Year. School nurses and faculty advisors provide counseling and condoms to 131 students in a total of 189 encounters (131 initial and 58 repeat).

1991-92 School Year. Counseling and condoms are provided to 157 students in a total of 328 encounters (157 initial and 171 repeat).

May 1992. The Committee on AIDS Education considers and rejects a proposal to allow student "peer helpers" to also make condoms available.

Fall 1992. A proposal to train student peer helpers to conduct HIV prevention education is accepted and students begin training.

B. HIV Education Efforts

Education and prevention efforts mandated by the board of education's AIDS policy include four components: (1) community education, (2) staff development, (3) curriculum and (4) disease transmission prevention.

The strategy of increasing **community education** includes providing an annual update to the community about HIV/AIDS through community forums and/or printed publications. **Staff development** is accomplished through annual training for all members of the school district staff about: information on HIV/AIDS; the means of controlling its spread; the role of the school in providing HIV prevention education; and school policies related to HIV-infected students and staff.

The emphasis of the **curriculum** encourages young people who have not engaged in sexual intercourse and who have not used illicit drugs to continue to abstain from both behaviors, and to encourage young people who have engaged in sexual intercourse or who have used illicit drugs to reconsider their decisions. Finally, the curriculum encourages those who decide to continue sexual intercourse and/or injected drug use to make decisions that will lower their risk of HIV infection; to use condoms and spermicide and to seek treatment for drug use.

The fourth and final strategy of the HIV education and prevention component, **disease transmission prevention**, is accomplished through providing students the opportunity to receive sexuality counseling and latex condoms from medically supervised professionals.

The Committee on AIDS Education made the strategic decision to implement the first three components of the policy before initiating condom availability (disease transmission prevention). While the board of education's policy would have permitted the district to implement all four components of the plan simultaneously, the committee decided it would be prudent to focus on community education, staff development and curriculum for the first year, allowing the controversy to die down and to better prepare the community for condom availability.

Several awareness activities took place in the 1988-89 school year. In August of 1988, the committee held a three-and-a-half hour in-service for all 800 school district employees covering the topics of epidemiology, medical manifestations of HIV and prevention strategies. The in-service included a presentation by a panel of people with AIDS.

The Committee on AIDS Education invited school administrators, parents and students to view and comment on five educational videos under consideration for use in the high schools. Of the five, the group chose the most explicit, "AIDS: Changing the Rules," which includes a demonstration of how to put a condom on a banana. The Committee on AIDS then invited all parents and community members to a screening of the video.

The video was shown to all students during one specific class period; because all classes participated, the assembly required the entire faculty to be involved. School officials note that the advantage of such a plan was that it created an environment that encouraged open discussion.

C. *Program Design*

The AIDS policy passed by the board of education did not specify how condoms were to be made available to students; the design had to be defined before the program could be implemented in the fall of 1989 (See Attachment II.D.5). The Committee on AIDS Education therefore turned its attention to designing the program (See Attachment G.1 at the end of this case study: "Guidelines for Disease Prevention Policy."). It considered options ranging from not making condoms available at all to providing them in vending machines or fishbowls. Eventually, the committee decided school nurses would be the only distribution point and developed an interview protocol to be used at each student's first request for condoms. In the second year, the program was expanded to augment the nurses with 22 trained volunteer faculty members called "faculty advisors." More students availed themselves of the condom availability program in the second year, leading school officials to surmise that some students feel more comfortable talking with teachers they know than with nurses they perhaps do not.

Parents may opt to keep their children out of the program. Each fall, a letter is sent to all students' homes, asking parents who do not want their child(ren) to receive sexuality counseling or condoms to sign and return the letter. The interview protocol designed by the Committee on AIDS Education requires that nurses or teachers ask the student's name before any counseling, and check it against the parental opt-out list. Students who have been opted-out by their parents cannot receive condoms or counseling. (See Attachments G.2 and G.3 at the end of this case study for: "HIV Exposure Risk Assesment" and "Health Services Protocol/Interviewer Protocol.")

A unique "condom kit" was designed for faculty volunteers. It consists of a black canvas bag equipped with condoms, resource information, a plastic banana for demonstrating condom use and a supply of interview forms. The bag has proven very helpful to teachers who do not have an assigned classroom but instead move around the building during the day.

Students in Adams County high schools also have access to condoms through the school-linked health centers run by Community Health Services (CHS). The board of education's AIDS policy designated CHS as one of the agencies under whose medical supervision condoms could be made available to students.

Prior to the board's decision, CHS did not provide any kind of contraceptive or STD prevention services. While the board of education called for CHS to supervise the school condom availability program, the CHS Board of Directors had to choose whether to take on that responsibility. After being educated about teenage sexual health issues, the board adopted a policy to provide contraception and testing for pregnancy and STDs at the health center. In 1990-91, a CHS center moved to a building adjacent to Adams City High School, making it more convenient for students to use CHS services.

Students enrolled as members of the CHS health center may receive condoms and other contraceptives; parents sign a form giving blanket permission for their child(ren) to receive all services provided at the health center. In addition, the health center's policy is that it will also provide confidential

contraceptive counseling and services to any student who requests them. Faculty advisors and nurses, however, cannot refer students on the parental opt-out list for these services.

D. Training

Each year, new volunteer faculty advisors receive training to help them become effective counselors and to increase their knowledge of HIV-related information. The training is conducted by the Committee on AIDS Education, with the assistance of state health and education department personnel and a local physician.

E. Funding

Local funds are used for all components of the HIV/AIDS education program, except for the condom availability program. The Colorado State Department of Health provides the condoms.

F. Evaluation

No outcome evaluation has been funded as yet, but the Committee on AIDS Education continues to monitor the condom availability program through process evaluation. Records are kept on how many students receive counseling and condoms each year, but names of individuals are not recorded in order to protect privacy and maintain confidentiality.

CPO acknowledges the assistance provided by Ms. Ronnee Rosenbaum, Executive Director of Community Health Services, in the development of this chronology.

Guidelines for Disease Prevention Policy

Adams County School District 14 provides comprehensive health services for its students. This is accomplished by working in cooperation with our community primary health care providers, with Commerce City Community Health Services, a building-based health clerk program and health care awareness programs. One program that is specifically offered focuses on sexually transmitted disease prevention. This program is available as a health service that is part of the comprehensive health services continuum. The district in no way condones or wishes to promote sexual activity outside of the context of marriage. However, the district recognizes that there are sexually active students. Our concern in offering this program is strictly from a student welfare and public health vantage point.

Those individuals who may elect to utilize this service or seek information related to this service are assured of their confidentiality.

I. COUNSELING AROUND SEXUALITY DECISION MAKING

A. Information around the availability of counseling and other confidential services will be made available through announcements in health education classes, in student handout materials, counseling office brochures/posters, and building staff. Training will be provided to school personnel around how to refer and to whom.

B. Parents retain the opportunity to with draw consent for their child's participation in this program. Annual notification will be given to parents of the availability of this program. A database will be provided to school personnel around how to refer and to whom.

C. AT THE STUDENT'S REQUEST, A CONFERENCE WITH AN APPROPRIATE MEDICALLY SUPERVISED VOLUNTEER MAY BE ARRANGED. SUCH VOLUNTEER WILL BE SCREENED AND SELECTED BY THE COMMITTEE ON AIDS EDUCATION FOR YOUTH AND TRAINED EXTENSIVELY THROUGH RESOURCES PROVIDED BY THE DISTRICT. MEDICAL SUPERVISION WILL BE PROVIDED THROUGH A CONTRACT FOR SERVICES BETWEEN THE SCHOOL DISTRICT AND COMMERCE CITY COMMUNITY HEALTH CENTER (CCCHS).

D. THE COMMITTEE ON AIDS WILL SPECIFICALLY DETERMINE THE PARAMETERS OF WHAT THE MEDICALLY SUPERVISED VOLUNTEERS ARE ALLOWED TO DO. THEIR ACTIVITIES MAY INCLUDE PROVIDING ACCURATE INFORMATION AROUND SEXUALLY TRANSMITTED DISEASES (STDs) EMPHASIZING INFORMATION ABOUT AIDS, INTERVIEWER PROTOCOL COMPLETION, DISTRIBUTION OF CONDOMS PER THIS POLICY GUIDELINE, AND REFERRAL UNTO THE SCHOOL NURSE FOR FURTHER COUNSELING AROUND MEDICAL AND SEXUALLY RELATED ISSUES. THIS GUIDELINE SPECIFICALLY INTENDS TO LIMIT THE RANGE OF INTERACTION THAT THE MEDICALLY SUPERVISED VOLUNTEER MAY HAVE WITH A STUDENT.

E. Statistical data will be maintained from this appointment, though no personally identifiable information will be recorded. The committee on AIDS Education for Youth will monitor all such statistical data.

F. Information on where testing can be attained regarding antibody status will be provided upon request.

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II. REFERRAL TO PHYSICIANS

A. Once the confidential CONFERENCE HAS OCCURRED, those individuals REFERRED TO ABOVE, upon evidence from the administration of an Interviewer Protocol, will determine if the need exists to refer a student TO THE SCHOOL NURSE. THE SCHOOL NURSE WILL THEN DETERMINE IF THE STUDENT SHOULD BE REFERRED ON FOR MORE IN-DEPTH MEDICAL EVALUATION. The Interviewer Protocol form is attached to this EXHIBIT EBBC-E.

B. Community physicians have agreed to participate with the full intent of this program through participation in a training effort completed during the summer of 1989 and by their awareness of the district's policy.

III. REQUEST FOR CONDOMS

A. The school nurse, AND appropriate medically supervised VOLUNTEERS may receive requests for the distribution of CONDOMS.

B. The agencies listed in the policy as well as other primary health care providers in the community also will be available to receive such requests.

IV. ACCESS TO DISTRIBUTION OF CONDOMS

A. Following the completion of the appointment, distribution of condoms may take place.

B. The agencies listed in the policy as well s other primary health care providers int he community also will be available to receive such requests.

V. OTHER SERVICES TO PROVIDE FOR A CARING, SUPPORTING AND HELPFUL SERVICE TO STUDENTS

A. During the initiation of the contract with the Student Advocate and/or School Nurse, other types of referrals for services may be made as appropriate and needed.

HIV Exposure Risk Assessment

REACHING THE STARS

TOUCHING THE FUTURE

ADAMS COUNTY SCHOOL DISTRICT 14

HIV EXPOSURE RISK ASSESSMENT

Please read the following list carefully to determine your risk for HIV exposure. If any of these apply, you may want to consider having an HIV antibody test.

ANY INFORMATION DISCUSSED IS CONFIDENTIAL

1. If you or your sexual partner(s) used intravenous (IV) drugs since 1979.
2. If you or your partner(s) had sex with someone who has used IV drugs.
3. If you or your partner ever had sex with anyone else.
4. If any of your sexual partners have been sick with AIDS, ARC (AIDS Related Complex), or tested positive for the AIDS antibody test (HIV positive).
5. If you or your sexual partner(s) have had a blood transfusion in the U.S. between 1979 and 1985 or since 1979 in a foreign country.
6. If you had artificial insemination with donor semen since 1979.
7. FOR WOMEN: If any of your sexual partners have been bisexual men or had sex with other men.
8. FOR MEN: If you ever had sexual contact with a man that included oral and/or anal intercourse.
9. If you have any reason to be concerned that you may have been exposed to HIV or any sexually transmitted disease.

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Health Services Protocol/Interviewer Protocol

1. What brought you in today?
2. I need to know your name so that I can check to see if your name is on the parent decline list.
3. Confidentiality Statement: I need to record information onto this questionnaire in order to keep data for evaluation of this program. I want to emphasize that no names are being kept on the questionnaire.
4. Descriptive information: [ ] Male [ ] Female Age: ____

   Ethnic background: [ ] Black [ ] Hispanic [ ] White
   [ ] Asian or Pacific Islander
   [ ] American Indian or Alaskan Native
   [ ] Other: _____
5. What do you know about condoms? How, when and where do you store and use condoms?
6. Do you feel you are at risk for STD/HIV exposure? [ ] Yes [ ] No

   If so, why (symptoms/behavior)?

   a) Do you know about STD/HIV testing?

   b) Where would you go to be tested?

   c) Are there concerns connected with your partner?
7. Where have you gotten STD/HIV information?
8. What are ways to avoid HIV exposure or infection?
9. Do you have other questions or health concerns?

---

10. How do you feel about this interview/process?

    · What could we do differently?

    - Handouts

Issued: 9/12/89
ACSD 14, Colorado

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II. PHILADELPHIA, PENNSYLVANIA

In June of 1991, as one part of a comprehensive policy to address adolescent sexuality, the Philadelphia Board of Education approved a policy allowing condom availability on a trial basis in the city's public high schools.

Philadelphia, the fifth-largest school district in the U.S., contains over 40 high schools serving approximately 60,000 students. The racial composition of the student population in grades K-12 is: 63 percent African-American; 23 percent white; 10 percent Hispanic; four percent Asian-American and less than one percent Native American.

The development of Philadelphia's condom availability initiative demonstrates how addressing condom availability within a broad context of the complex issues of adolescent sexuality can increase its acceptability.

A. Chronology

November 1990. The Philadelphia Task Force on Adolescent Sexuality and the Role of the Schools in the Prevention of Pregnancy, HIV and other STDs is established by the board of education to address issues of adolescent sexuality, pregnancy, HIV and other STD prevention. Task force members include health professionals, educators, parents, community activists and religious leaders.

March 1991. The Task Force on Adolescent Sexuality issues a report outlining several programs and policy options pertaining to adolescent sexuality. The options for condom availability range from prohibiting school condom availability to putting vending machines in the schools.

April-May 1991. The board of education holds eight community hearings over 10 weeks throughout the city. The hearings are planned to cover the entire comprehensive policy, but most of the testimony focuses on condom availability. Hundreds of people on both sides of the issue participate.

June 24, 1991. The board of education approves six to three a policy allowing condom availability in the public high schools as one component of a broader teen pregnancy, HIV and other STD prevention program and sexuality education plan. In addition to condom availability, the plan calls for a revision of the K-12 abstinence-based curriculum, the development and maintenance of a comprehensive training program on adolescent sexuality for school staff and the creation of training and support resources for parents.

Fall 1991. Experts in HIV, minority health and adolescent medicine plan the implementation of condom availability. As part of the evaluation plan, focus groups are held with students to collect baseline information and refine the design of the drop-in centers where condoms will be made available.

A Philadelphia group called "Parents United for Better Schools" files a suit to enjoin the school district from proceeding with the program. The group alleges that the program exceeds the scope of the board's authority and asks for a permanent injunction.

December 16, 1991. The first school begins making condoms available through a drop-in center.

May and Fall 1992. Condoms are available at nine schools. Two schools operate their condom availability programs in their school-based health centers.

B. Program Design

Adolescent health "drop-in centers" are to be established in each of Philadelphia's 40 high schools. Students are free to visit these centers without appointments to receive counseling, health and social service referrals and condoms. The centers are integrated into already existing health care and student support program and complement the nurse, guidance counselors and family support staff.

Each high school, through the principal in concert with faculty, health providers and parents, plans the details of its program. Each project conducts student focus groups to name the center, determine certain activities and services and design the marketing scheme within the school.

The drop-in centers are centrally located and are open when students have free time (before school, after school and lunch time). There is no receptionist or secretary to create a barrier; students can walk in and talk to a professional immediately. Pediatricians supervise staff and activities. Counseling is conducted by social workers, nurses, health educators and, in some schools, medical or social work students. The centers contain areas for private counseling, as well as for group sessions.

The board of education's mandate specifies that school district funds not be used to run the program and that condoms be made available under the aegis of a local health care organization. Actual providers of condoms must be pediatricians, social workers or health educators. Receipt of condoms must be accompanied by extensive counseling and education to include abstinence and effective use of condoms.

At the beginning of the school year, the principal sends parents a letter, written in English and Spanish, with a return form by which parents can opt the student(s) out.

Confidential records are maintained on each encounter and include information on services provided, referrals made and any follow-up notes. Records are also kept on students whose parents withheld permission for participation; these students are not able to receive condoms, although they may obtain confidential counseling and referrals.

Educational materials approved by the school district are available to students and parents at the center. Topics include AIDS, abstinence, STDs, pregnancy prevention, prenatal care, parenting skills, acne, drugs, cancer prevention, voter registration, local colleges and schedules for upcoming events.

Each drop-in center is required to develop plans to make condoms available to students during the summer and school vacations. Some schools remain open over the summer, and their drop-in centers are also open. During the summer of 1992, arrangements were made with 32 family planning clinics where students could receive free condoms.

C. Funding

The board of education's policy restricts the use of district funds for either staffing or condom purchase. Outside health organizations have organized and continue to administer the program.

The Family Planning Council (the local Title X recipient) provided start-up funds for five centers, as well as technical assistance and training support for all of the centers. The board of education authorized the use of space in the

schools for the drop-in centers. Philadelphia's Department of Health provided 500,000 condoms and $60,000 for educational brochures on HIV, STDs and condom use. After 1992, plans call for operation of the drop-in centers with a mixture of public and private funding. Each center's annual operating costs are $30,000.

D. Evaluation

Several types of evaluation are being conducted. Data, reported on a monthly basis by all drop-in centers, include the number and demographics of users, number of initial and return visits, services provided, referrals made and the number of condoms dispensed. On a quarterly basis, this information is compared with the total school population to determine utilization rates and make comparisons. Focus groups with users and non-users of the centers are conducted periodically to monitor the effectiveness of the program. (See Attachment V.A in Chapter 5 for sample log forms.)

The Family Planning Council conducted several focus groups with students to obtain their thoughts on program design. In addition, a written survey of other students was conducted.

Funds are currently being sought to conduct evaluations measuring the impact of the program at both the individual and community level.

CPO acknowledges the assistance provided by Ms. Wendy Mahoney, Program Manager at the Family Planning Council, in the development of this chronology.

III. NEW YORK CITY, NEW YORK

The New York City Board of Education made history on February 27th, 1991, when it adopted an HIV/AIDS education and prevention program that is the most far-reaching of any school district in the United States. The Expanded HIV/AIDS Education Program Including Condom Availability is a comprehensive education program that includes condom availability – with no parental opt-out provision – for all students enrolled in New York City high schools.

New York's is the largest school district in the country, educating close to one million students in 1,200 schools. The school district is ethnically and culturally diverse, as reflected in 1989-90 demographic data that show the school population is 37.8 percent African-American, 34.7 percent Hispanic, 19.6 percent white and 7.8 percent Asian-American. New York City is one of the largest epicenters for the HIV epidemic and shows some of the highest seroprevalence rates for adolescents in the country.

The chronology of the New York City public schools' response to the AIDS epidemic demonstrates several important points. First, the school district initially did little while the epidemic spread. Second, once leadership on the issue emerged, movement was very fast: condom availability was approved in February 1991, and by February, 1992, 15 high schools operated condom availability programs. By June, 1992, 112 of 124 high schools had programs. The fast pace was important; the political reality was such that the longer the program took to be implemented, the more time the opposition would have to organize against it. Third, school district personnel were able to collaborate with a wide range of outside experts in planning and implementing the program.

A. Chronology

Fall 1985. In response to the disclosure that a second grader with AIDS would attend public school in the fall, Queens parents call for the child's expulsion and keep their children away from school. In the ensuing lawsuit, a department of health report reveals that between 200 and 2,000 public school children may have HIV.

New York City Public Schools Chancellor Nathan Quinones, in cooperation with Stephen Joseph, New York City Commissioner of Health, assembles an AIDS committee to deal with pediatric AIDS in the public school system. Quinones calls for a day of HIV/AIDS education in the classroom, the first in the city's public schools.

October 1986. Six high-school-based health centers are the focus of press attention for providing condoms and birth control prescriptions as part of their health services.

May 1987. Health Commissioner Joseph criticizes the board of education for not being vigorous enough in educating students about AIDS; he states that condoms should be made available in high school health centers to prevent the spread of the disease.

June 1987. The board of education adopts a resolution preventing condom availability in school-based health centers. The resolution permits health center staff to write prescriptions for condoms and other contraceptives, and allows for parental opt-out.

The Commissioner of the New York State Education Department promulgates regulations regarding a statewide HIV/AIDS curriculum and the require-

ment that every school district form an advisory council on HIV/AIDS prevention education.

Fall 1987. The New York State Department of Education issues an AIDS instructional guide for grades K-12.

The New York City Public Schools Office of Health, Physical Education and School Sports convenes an Advisory Council on HIV and AIDS in response to new state regulations.

May 1989. As part of his implementation strategy for achieving compliance with the state mandates, Schools Chancellor Richard Green issues a memorandum mandating that students in grades 7-12 receive a minimum of six lessons, per grade, of HIV/AIDS prevention instruction.

January 1990. Joseph Fernandez becomes New York City Schools Chancellor. On his first day as Chancellor, ACT-UP (an AIDS advocacy group) demonstrates in front of the board of education building, calling for improved AIDS prevention education in the schools.

Spring 1990. Chancellor Fernandez conducts a survey, with the assistance of outside agencies, of over 300 schools to assess the status of AIDS prevention education. The Women's City Club, a local government watchdog agency, conducts a similar survey; both reveal that schools are out of compliance with chancellor's standards and state regulations.

June 1990. A subcommittee of the Advisory Council on HIV and AIDS presents the Chancellor with a position paper containing 13 recommendations, including one to provide condoms through school-based centers serving high school students.

August 1990. Chancellor Fernandez endorses all the recommendations of the Advisory Council on HIV and AIDS, with the exception of condom availability.

September 1990. *U.S. News and World Report*, in a profile of the chancellor, reports his plan to press for condom availability in city schools. The following day, all four New York daily newspapers carry lead stories about his desire to expand AIDS prevention education in the schools and to make condoms available to high school students.

AIDS activists, adolescent and public school advocates, parents and students attend the first public agenda board meeting in September and show their support for the chancellor's proposal.

October 1990. To develop the expanded AIDS prevention education plan, the chancellor's staff convenes an internal working group of representatives from central administration offices, including: health, guidance services, substance abuse prevention, research, evaluation and assessment, public affairs and human resources.

Chancellor Fernandez and a local union cosponsor the first city-wide conference on AIDS education for parents, students and school faculty.

The Coalition of Concerned Clergy organizes to oppose the chancellor's call for an expanded AIDS prevention education program.

October-December 1990. The internal working group is convened, including parents, faculty and students, and develops a plan to achieve the chancellor's vision for expanded AIDS education. The draft plan includes condom availability.

December 1990. Chancellor Fernandez proposes that, under his plan, condoms be made available on request to high school students without parental consent. The New York State AIDS Advisory Council's Ad Hoc Committee on Adolescents and HIV unanimously endorses the chancellor's plan.

A poll of 1,010 New York City adults conducted by the Gallup Organization for *New York Newsday* shows 60 percent support condom availability in high schools. A majority of men, women, whites, African-Americans, Hispanics, residents of four of the city's five boroughs, Catholics, Jews and parents (with and without children in public school) support the policy. Support also cuts across income groups and education levels.

January 1991. A revised version of the chancellor's plan is released, incorporating suggestions to include parents on each school's HIV/AIDS team and to provide an 18-month phase-in period for implementation.

February 1991. The New York City Board of Education holds an 11-hour public meeting on the plan, for which 277 people sign up to speak.

The board of education adopts the chancellor's plan by a narrow margin of four to three.

February-March 1991. A committee composed of 12 high school principals and their health educators assists the chancellor's staff in writing implementation guidelines for condom availability.

March 1991. Curriculum review begins, involving health educators, outside HIV/AIDS professionals, curriculum writers, central board of education offices and national leaders.

Implementation guidelines are finalized and hand-delivered to every high school (See Attachment G at the end of this case study: "Expanded HIV/AIDS Program Implementation.").

Board of education member Carol Gresser of Queens announces she will introduce a parental opt-out amendment to the plan at the board's next meeting.

March-June 1991. A Training Committee is convened to design the training component of the program. Many outside organizations lend their expertise to this committee, including the city and state departments of health, the state education department, the state AIDS Institute, local community-based health providers, adolescent advocates and AIDS experts, including the American Foundation for AIDS Research (AmFAR).

May 1991. Thirty-nine high school HIV/AIDS Education Teams (composed of staff, faculty, students and parents) submit plans to improve HIV/AIDS education and make condoms available to students. A committee to review teams' proposals convenes with representatives from public health authorities, adolescent AIDS providers, unions, community-based organizations, health educators, public school personnel and parents. This committee is charged with reading each HIV/AIDS Education Team's plan and assessing the teams' readiness to receive condom availability training.

June 1991. Based on implementation plans submitted, 16 high schools' HIV/AIDS Education Teams are selected to receive training. The first training, sponsored by the New York Academy of Medicine, is attended by over 200 school community members including students, parents and faculty.

The chancellor's office secures the donation of 450,000 condoms from two leading condom manufacturers and $100,000 to establish a small grant program for student-developed AIDS education projects. In addition, approximately $500,000 is raised to hire a team of HIV experts to assist the school district in implementing the program.

July 1991. Chancellor Fernandez invites representatives of academic institutions from across the country to meet with him to discuss the Expanded HIV/AIDS Education Program, including Condom Availability. As a result of this two-hour meeting, outside organizations undertake eight evaluation initiatives.

Summer 1991. Some board of education members discuss their intention to introduce parental opt-out provision. The advocacy community maintains its opposition to parental opt-out while those who oppose the entire plan voice their support for it.

The Board of Regents, which sets public education policy for New York State, votes 12 to three to affirm current policy. The education commissioner rules that current policy permits condom availability programs in public schools. This action effectively endorses the New York City plan, the only such initiative in the state.

August 1991. The State Committee on Open Government, in an advisory opinion responding to a complaint lodged by the Public Education Association, rules that a closed executive session of the New York City Board of Education on parental opt-out violated the state's Open Meetings Law.

For the first time since the passage of the plan, the board holds a discussion at a public meeting of the addition of a parental opt-out amendment and places the issue on its calendar.

September 1991. The board of education votes four to three to defeat parental opt-out.

Fall 1991. The board of education appoints an HIV/AIDS Advisory Counsel, in compliance with state law.

November, 1991. A lawsuit, *Alfonso v. Fernandez*, is filed by Michael Petrides, a member of the board of education, and two parents from Staten Island in the New York State Supreme Court of Richmond County. The plaintiffs claim the chancellor's condom availability plan violates parents' rights by not including parental opt-out.

November 1991. Training begins in two of the first 16 schools to implement condom availability programs.

January 1992. Condom availability programs are in place in 15 of the 16 schools, reaching more than 35,000 students in communities across the city.

April 1992. On April 23, the New York Supreme Court rejects all claims in *Alfonso v. Fernandez*, upholding the right of the board of education to make condoms available to high school students without parental consent. (In New York, the Supreme Court is the trial court, the Appellate Division is the intermediate appellate court and the Court of Appeals is the court of last resort.) Plaintiffs filed an appeal and oral arguments were heard in January, 1993.

May 1992. The board of education adopts a resolution requiring that abstinence be stressed more than half of the time when discussing AIDS prevention and that condom usage never be represented as equal to abstinence as a prevention strategy. Additionally, the resolution calls for a "morality oath" that must be

signed by all outside agencies and individuals seeking to present AIDS education in schools; the oath requires that signers adhere to the rules about abstinence messages.

June 1992. One hundred twelve of 124 high schools are approved to implement the condom availability portion of the comprehensive HIV/AIDS prevention education program.

July 1992. The New York Civil Liberties Union, in cooperation with physicians, parents, students and public officials, files suit with the New York State Department of Education in *Knowledge v. Board of Education of the City of New York*. The New York Civil Liberties Union claims that the board's abstinence requirement conflicts with state regulations and law concerning other education goals and policies, as well as violates faculty and student rights of academic freedom.

The Commissioner of the New York City Department of Health publicly denounces the "morality oath" as an impediment to effective AIDS education.

September 1992. The "morality oath" is released for use. (Of more than 60 community organizations that have assisted in providing HIV/AIDS education and services, 40 have refused to sign this pledge and have been barred from the schools as of the end of 1992.)

HIV/AIDS Education Teams in remaining schools continue to be approved for training and implementation.

The board of education repeals the policy prohibiting school-based health centers from providing contraceptives.

October 1992. A hearing on the "morality oath" is held before New York's top education official, State Commissioner of Education Dr. Thomas Sobol, who is empowered to review all decisions by local school boards.

February 8, 1993. The State Commissioner of Education overturns the "morality oath," stating the board had overstepped its authority and infringed upon teachers' rights.

February 10, 1993. The board of education votes 4-3 against negotiating a new contract with Chancellor Fernandez when his present term expires in June. Board members voting against Fernandez cited his authoritarian manner and habit of micromanaging as well as their desire to focus attention on "basic" skills rather than "peripheral" social issues. The members who opposed Fernandez represent outlying boroughs where his concentration on AIDS and other social problems met with greatest opposition.

B. The Expanded HIV/AIDS Education Program

The chancellor's plan for an expanded HIV/AIDS education program seeks to raise awareness about HIV/AIDS and to encourage students to adopt risk-reduction behaviors including effective condom use, abstinence from sexual intercourse and the elimination of drug use. The program mandates that each New York City public high school form an HIV/AIDS Education Team that includes teachers, parents, students, the school principal and other school staff and may be supplemented by HIV/AIDS educators and experts. The principal is responsible for the success of the program.

In keeping with the chancellor's agenda of encouraging school-based decision-making, the teams are the primary planners of HIV/AIDS education in their schools. Each year, teams must provide a minimum of six lessons on HIV/AIDS to each grade and an HIV/AIDS information session for parents.

C. Program Design

Each school's HIV/AIDS Education Team must design an HIV/AIDS education plan based on the chancellor's guidelines. The condom availability portion of the plan must meet several guidelines.

First, the teams are mandated to designate at least one area within the school as a health resource site where condoms and other health resources will be made available by a volunteer staff member. The site cannot be in the school-based health center where, according to an earlier board of education resolution, contraceptives cannot be made available. (This restriction was lifted by the board of education in September, 1992.)

Second, the site must be staffed at least 10 periods each week at a variety of times during the school day. Schools are encouraged to arrange more staffing time if possible. Condoms can also be made available before and after school or at other times convenient to students. The schedule of all health resource site hours must be posted and accessible to all students.

Third, at least one male and one female volunteer must be identified to make condoms available to students. These individuals will be responsible for providing condoms upon request and answering questions based on their training. Each condom given to a student is accompanied by a manufacturer's pamphlet explaining correct usage. Pamphlets are available in all languages spoken by public school students.

Fourth, each school's plan must describe the process by which every student will be informed about all services provided on the school site, including the availability of condoms and counseling, the names of staff who have volunteered to staff the sites and members of the HIV/AIDS Team.

Once a school's team has completed training, a site visit by the committee is scheduled. At that visit, team members must agree they are ready before they are authorized to make condoms available.

D. Training

A range of organizations provides *pro bono* training services. These include AIDS organizations, youth-serving agencies, universities, state and city health departments and the United Federation of Teachers. Twenty-five different organizations lent trainers and training expertise to the first round of training in 1991.

Participation in training is required of all schools' HIV/AIDS Education Teams. It is offered to parents, students, faculty and staff on the teams. Response to the inclusion of these constituencies has been overwhelmingly positive. The training design includes three components:

1. A half-day orientation session for all HIV/AIDS Education Team members (parents, students, faculty, staff) focusing on information and motivation.
2. A full-day training for all team members, including students and parents, focusing on team building, understanding adolescence and gaining information about HIV infection and related health topics (Tier I). These sessions are conducted in small groups to facilitate interaction.
3. Two full days of training for faculty and staff only, focusing on learning and practicing relevant skills for counseling and providing

condoms. Topics include: encouraging abstinence and resisting peer pressure; risks of use and misuse of condoms; adolescent sexuality and development; communication skills-building and referral sources (Tier II). (See Attachments IV.F and G, "Components of Training" and "Guidelines for Individual Counseling" in Chapter 4.)

E. Funding

The New York City Public Schools receive federal and state funds for AIDS prevention education. That funding is used for curriculum and staff development to implement the Expanded HIV/AIDS Education program. More than one million dollars in private funds, almost half from the Aaron Diamond Foundation, were raised to implement the condom availability portion of the comprehensive plan. Those funds were used to support the hiring of technical assistance teams comprised of HIV/AIDS experts and to implement a small grant program for student-developed AIDS education programs. Carter-Wallace, Inc. and London International, two leading condom manufacturers, donated condoms for the first year of the program; Carter-Wallace, Inc., agreed to donate condoms for the second year.

F. Evaluation

Karen Hein, Professor of Pediatrics, Associate Professor of Social Medicine and Epidemiology at Albert Einstein College of Medicine and Director and founder of the AIDS and Adolescents Program at Montefiore Hospital provided the chancellor with *pro bono* assistance and advice in the recruitment of outside organizations to conduct a longitudinal study of the impact of the program on students.

Eight different outside evaluators are engaged in evaluating various segments of the entire expanded HIV/AIDS prevention education plan for grades K-12. A collaborative effort of the National Center for Health Education, the Academy of Educational Development, New York University and Hunter College focuses on an evaluation of the condom availability program.

The Office of Research, Evaluation and Assessment (OREA) of the New York City Public Schools is responsible for the in-house documentation and evaluation of both the training and program implementation.

OREA staff evaluated the training of the school HIV/AIDS Education Teams by observing most of the trainings in the fall of 1991 and taking extensive field notes. Participant feedback was obtained through anonymous, self-administered questionnaires filled out after all trainings. Participant surveys elicited feedback in the following areas:

- overall assessment of the usefulness of the training
- assessment of how informative participants find each component of the training
- assessment of the relevance of the material presented
- identification of additional needs for information, training, technical assistance and other resources
- participants' comfort level with their role in planning and implementing the program.

OREA staff also document and assess the implementation of the program in the schools. Through qualitative analysis, the research identifies strategies, activities and school characteristics associated with program "success" defined by each school. In addition, the research documents barriers encountered and

methods for overcoming them. Data are gathered from a sample of schools by means of site visits, interviews and focus groups. This evaluation explores the following areas:

- composition, roles, responsibility and function of the HIV/AIDS Education Teams
- implementation of the HIV/AIDS curriculum, including integration of the topic into diverse subject areas, assessment of training curriculum and resource materials and gaps
- types of activities conducted to increase knowledge, build HIV/AIDS awareness or change attitudes
- student, teacher and school response to condom availability, including number of student "visits" for condoms and the types of information and counseling requested
- parental involvement.

CPO acknowledges the assistance provided by Ms. Jill Blair, former Assistant to Chancellor Joseph A. Fernandez, in the development of this chronology.

Expanded HIV/AIDS Program Implementation Guidelines, New York City

OFFICE OF THE CHANCELLOR

JOSEPH A. FERNANDEZ
CHANCELLOR

MEMORANDUM

March 26, 1991

TO: HIGH SCHOOL SUPERINTENDENTS, HIGH SCHOOL PRINCIPALS, PARENT ASSOCIATION PRESIDENTS, SBM/SDM CHAIRS, UFT CHAPTER CHAIRS, HIV/AIDS EDUCATION TEAMS

FROM: Joseph A. Fernandez
Chancellor

SUBJECT: Expanded HIV/AIDS Program Implementation Guidelines

Attached are guidelines for program implementation of the Expanded HIV/AIDS Program Including Condom Availability. These guidelines were devised in consultation with high school principals, health educators, and guidance staff. Please do not hesitate to call on my staff if we can be of any assistance. Individuals and their numbers are included in the guidelines.

I want to thank everyone who has been involved in this process and wish you great success in developing individual school plans. You have my full support.

JAF:sw
Attachment

NEW YORK CITY PUBLIC SCHOOLS • 110 LIVINGSTON STREET • BROOKLYN, NEW YORK 11201

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GUIDELINES FOR HIV/AIDS PROGRAM IMPLEMENTATION IN THE HIGH SCHOOLS

INTRODUCTION

On February 27, 1991 the New York City Board of Education held a historic vote in favor of a bold new plan for Expanded HIV/AIDS Education Including Condom Availability in the high schools. The intent of the plan is to raise awareness about HIV/AIDS and encourage students to abstain from high risk behavior, including sexual intercourse and substance abuse. What follows are the guidelines for implementing this program.

Every high school is required to develop its own school-based plan for program implementation. That plan should describe each school's HIV/AIDS Education program including the strategy for making condoms available. All support services that impact the plan should be included and, to the extent possible, representatives from those programs should be included in each school's HIV/AIDS Education Team. For those who are interested, there will be a technical assistance meeting for schools to provide assistance in completing their plans. This will take place on April 12, 1991 at Junior High School 17, 328 West 48 Street, New York, New York at 9:00 a.m.

A timeline for training and implementation is included. A sample format of the plan is attached.

If there are questions about any aspect of this document, please call:

Larry Edwards, Director of Office of Access and Compliance, Division of High Schools, (718)935-3415

Jerome Rosenzweig, Acting Director, Office of Health, Physical Education, and School Sports, Division of Instruction and Professional Development, (718)935-4140

Georganne Del Canto, Assistant Director, Office of Health, Physical Education and School Sports, Division of Instruction and Professional Development, (718)935-4140

If assistance is needed in identifying interagency resources for plan development, please call Sarah Williams, Coordinator of External Resources, Office of the Deputy Chancellor for External Programs and Community Affairs, (718)935-2778.

I. TEAM DEVELOPMENT

MANDATE 1:

Every high school is required to form or expand its HIV/AIDS Education Team. Participants must include but are not limited to the following:

- Principal;
- Assistant Principal;
- Teachers--there must be one, and preferably more than one, teacher on each team;
- Parents--there must be at least one, and preferably more than one, parent on each team;
- Students--there must be at least one, and preferably more than one, student on each team;
- Health Resource Staff--the individuals who volunteer and are trained to make condoms available are required to be members of each team.

Teams should be extended to other members of the school community including, but not limited to, supervisors, deans, social workers, guidance counselors, SPARK counselors, special education staff, school-based clinic personnel, health aides, paraprofessionals, and school security personnel.

From this team, a leader or facilitator must be established. Efforts should be made to accommodate meeting times for all team members. In SBM/SDM schools, a liaison should be established between the HIV/AIDS and the SBM/SDM teams. Responsibilities for the composition of the team and success of the school program rest with the principal.

In addition, the importance and value of integrating other school health efforts into this program cannot be stressed enough. Members of the broader community who have expertise in the areas of health, teen sexuality, and HIV/AIDS are encouraged to be included. Each plan should list team members and titles as well as describe how other programs and services will be integrated to provide a comprehensive plan.

Role of Team:

The HIV/AIDS team will be the primary facilitators and planners of HIV/AIDS education in their schools. Each plan must describe how the role of the team is defined and, specifically, its responsibilities. Suggestions for team activities include:

- drafting a statement outlining the team's role in the school and a year-to-year plan;
- assuming responsibility for reviewing resource materials to be used as part of the HIV/AIDS initiative for their appropriateness and quality;
- identifying who should teach the HIV/AIDS lessons (see section on Instruction and Curriculum);
- recruiting, and incorporating outside agencies into the school's HIV/AIDS program;
- defining and enforcing a policy for maintaining the confidentiality of students who obtain condoms;
- creating the calendar of HIV/AIDS education activities for the school year;
- outlining an internal assessment process for the program;
- identifying on-site counseling services for students or establishing a referral process to outside agencies that provide these services. In addition to the whole range of support programs, counseling services should include those specifically related to HIV/AIDS such as testing for HIV, bereavement counseling, HIV/AIDS support and treatment programs, etc.

II. INSTRUCTION AND CURRICULUM

MANDATE 2:

Each plan must state how, in each grade, the required six lessons on HIV/AIDS will be taught.

Attached is a copy of the current curriculum for grades 9-12. These lessons can be taught in a variety of ways including through social studies, health, or science. School plans should reflect an effort to integrate the subject of HIV/AIDS instruction into as many content areas as possible.

The current 7-12 HIV/AIDS curriculum is being revised and a draft should be available for review in the Fall of 1991. Training that includes information on the new curriculum and the specifics of the condom availability component will be provided. According to the State Commissioner of Education's Regulations on HIV/AIDS Education (Subchapter G, part 135), before the curriculum is taught parents must be informed of their right to opt their child out of prevention lessons. If a parent chooses to opt their child out, they must submit in writing a statement that ensures that they will provide the same information to their child at home. Parents cannot opt their children out of the condom availability component of the HIV/AIDS program.

III. LOCATION OF CONDOMS AND OTHER HEALTH RESOURCES

MANDATE 3:

Each school is required to designate at least one area within the school (not the school-based health clinic) where condoms and other health resources will be made available. The space should offer privacy and should be outfitted with information on HIV/AIDS, sexually transmitted diseases, and other health issues.

If health materials are needed, please contact John Torres, AIDS Resource Center, (212)385-2704. There may be additional sites where condoms can be made available such as the guidance counselor's office. If more than one site is identified, please explain what health resources will be available at each site.

Because of technical issues, school based health clinics cannot make condoms available at this time. Efforts are underway to resolve this issue with the New York City Department of Health and the Board of Education. It is expected to be addressed before September, 1991. Those schools that have clinics can include in their plans their intention to use this site for condom availability in the future, pending Board approval. Schools will be kept posted on the status of this issue.

MANDATE 4:

The health resource site must be staffed at least ten periods each week at a variety of times during the school day.

Schools are encouraged to arrange more staffing time if possible. Condoms can also be made available before and after school and at additional times that are easily accessible to students.

Each condom will be accompanied by the manufacturer's pamphlet explaining correct usage. A videotape will also be made available that demonstrates condom use.

MANDATE 5:

After condoms are delivered to the school, the school is responsible for their security. Each school's plan must include a method of locking and storing the condoms to prevent tampering and damage.

MANDATE 6:

The schedule of the health resource space hours must be posted and accessible to all students. Each school's plan should describe the method for communicating this schedule to the students.

IV. CONDOM AVAILABILITY STAFF

MANDATE 7:

At least one male and one female volunteer must be identified to make condoms available.

These individuals will be responsible for providing condoms upon request and answering questions based on the training they have received. For support services personnel who volunteer, staffing a health resource site may be incorporated into their ongoing responsibilities. For teachers with full teaching loads who volunteer to staff the health resource site, there are several options for scheduling. A schedule could be established for teachers to use their professional period, in some cases their building period, or other mutually agreed upon times.

Volunteers must perform their responsibilities in accordance with the guidelines established by the New York City Public Schools and set forth in an approved plan. A thorough review of all legal issues will be included in the training for the condom availability volunteers.

Individuals who have volunteered to staff the health resource sites will receive ongoing technical support and have group meetings coordinated by the Office of Health, Physical Education, and School Sports.

V. STUDENT ORIENTATION

MANDATE 8:

Schools will be required to inform every student, including over-the-counter registrants and students whose home language is other than English, about all services provided on the school site, including the availability of condoms and counseling, names of staff who have volunteered to staff the health resource site(s), and members of the HIV/AIDS team. Each school's plan should describe the process for conveying this information.

The expanded HIV/AIDS Education Program should have as its primary emphasis the importance of abstaining from risk behaviors including sexual intercourse and substance abuse. Condom availability must be placed in this broader context. Students must understand the implications of their actions and the potential consequences of engaging in high risk behaviors.

The condom availability component cannot be implemented until school staff have successfully completed the training and students have received orientation as to the role and resources of the health resource site.

VI. PARENTS

MANDATE 9:

Schools must provide a HIV/AIDS information session for parents.

Organized in conjunction with each school's Parents' Association, the HIV/AIDS team members, and any additional parents with expertise in the health field, this forum should include basic information on HIV/AIDS transmission and suggestions for parents on how to discuss difficult issues with their children. Information for parents whose home language is other than English should be included in the presentation. The Chancellor's Office will arrange for support in implementing this forum. For assistance in securing speakers and facilitators for these programs, please call Sarah Williams, Coordinator of External Resources, (718)935-2778.

VII. WAIVERS

Reasonable requests for waivers from the mandates of this plan will be entertained. If a school requests a waiver from any of the mandated components, the reasons why a waiver is sought should be included. Requests will be considered in the context of a school's overall plan to improve the quality of HIV/AIDS education in the school.

VIII. MONITORING AND EVALUATION

Each team is responsible for determining a method of internal assessment for their HIV/AIDS Education Program. The purpose of the assessment is for each school to set its own standards and measurements for how their HIV/AIDS Education Program is operating and ways it could be improved.

In conjunction with the Office of Research, Evaluation, and Assessment, the Office of Monitoring and School Improvement will monitor and document the implementation of the Expanded HIV/AIDS Education Program.

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TEAM RESOURCES AND SUPPORT TIMELINE

Deadlines

Two deadlines have been established for the submission of the HIV/AIDS Education Plan:

May 1, 1991

June 3, 1991

The schools that submit plans by May 1, 1991 will be notified by June 1, 1991 about whether their plan has been accepted for implementation. There will be an orientation in June for those teams whose plans are accepted. Schools that submit plans by June 3, 1991 will be notified in September. For these teams, the orientation will be offered in September. The full training for team members with approved plans will begin in October, 1991.

Training

After each school's plan is submitted, training and support will be provided to each team in the following ways.

Orientation

This orientation will provide an overview of the program as well as an opportunity to share information and strategies with other schools. Topics will include: a discussion of model plans, preliminary team building exercises, and the role and responsibilities of the team.

Tier I Training

Tier I training will be offered for the HIV/AIDS Education Teams. All team members including students, are required to attend. The session will be scheduled during a school day between the hours of 9:00 a.m. and 3:00 p.m. If parents are unable to attend, an additional training will be scheduled to accommodate them. Topics to be covered in Tier I training include:

- an overview of the epidemic;
- teen sexuality;
- behavioral issues of youth;
- key elements of the curriculum;
- resource referral information and strategies;
- team building exercises;
- politics of implementation.

Tier II Training

Tier II training is for the individuals who will staff the health resource locations and give condoms to those students who request them. For schools that submit approved plans in May of 1991, Tier II training will be offered in October. For those schools that submit approved plans in June, Tier II training will be offered late in the fall of 1991. Through the intensive 9:00 a.m. - 3:00 p.m. two day training, volunteers will learn very specific information on HIV/AIDS, adolescent sexuality, resource referral, multicultural sensitivity, behavioral issues for teens, condom usage, and techniques for addressing sensitive topics with teens.

EXTERNAL RESOURCES

As mentioned earlier, health leaders in all fields have offered their assistance in implementing this program. The Office of the Chancellor has also worked to identify additional community-based organizations, academic institutions, and service providers that have experience and are interested in assisting schools. As a result, many resources are available as teams work to formulate and implement their plan. The following is a partial list of expertise and support activities from which teams may draw:

- the New York City Department of Health: training programs, in partnership with the New York City Public Schools; and directories of community based organizations available to work with schools;
- the New York City Health and Hospitals Corporation: advice, technical assistance, and referrals;
- the Food and Drug Administration: brochures and literature on HIV/AIDS;
- medical schools and hospitals: assistance with training, speakers for school forums, or "adopting" a school and serving as an advisor to an HIV/AIDS team;
- videotape on appropriate condom use;
- not-for-profit organizations with health programs for referrals and facilitators to assist with planning;

EXTERNAL RESOURCES (CONT'D)

- speaker's bureaus with health experts to address parents at school forums or conduct workshops on the issue of HIV/AIDS.
- the American Foundation for AIDS Research: Resource Directories and possible training and technical assistance for program implementation;
- a small grants program for student developed projects on health and HIV/AIDS education (available January 1992)*;
- technical assistance provided by a not-for-profit health organization with private foundation support**;

A memo is being drafted on suggested screening procedures to help teams evaluate the appropriateness and educational value of the activities of outside organizations. It will be sent to you this spring.

- In April of 1991, the Chancellor will formally announce the establishment of the Health HIV/AIDS Fund for the New York City Public Schools. This Fund, established with grants from foundations and corporations, will provide small grants (up to $2500) for student-developed education projects that increase student and community awareness of health and HIV/AIDS issues.

** With a grant from the Aaron Diamond Foundation and in collaboration with the New York City Department of Health, the Office of the Chancellor is developing a program that will provide professional health advocates and technical assistance to high schools as they begin implementing their plans. This service will be available in the fall of 1991. Further information will be provided as it becomes available.

CHAPTER EIGHT

SCHOOL-BASED HEALTH CENTERS

School-based or school-linked health centers, located on or near school grounds, provide primary medical and mental health services for students enrolled in their programs. They typically represent a collaborative effort on the part of the school and the local health department, community health center or local hospital to meet the needs of adolescents with few alternative sources of health care. School-based health centers (SBHCs) are usually staffed with a nurse practitioner or physician's assistant, a part-time physician, a social worker, a health educator and a receptionist. Research indicates that these centers create accessible and comfortable environments for meeting students' health-related concerns.

Confidential, free and easily accessed, SBHCs provide a logical place to make condoms available. Nearly all provide some family planning services, including counseling and referral for contraceptives. However, only about 18 percent of SBHCs provide condoms and other contraceptives on site. Restrictive state or local policies limit services at the majority of centers.

In a few states, laws prohibit contraceptive services on school grounds. Most often, whether an SBHC provides family planning services is a policy decision made by the local school board or sponsoring health agency when the center is authorized. Many centers, seeking to avoid controversy and religious opposition, have chosen not to offer contraceptives on site.

Recently, in light of the epidemic number of teens infected with sexually transmitted diseases (STDs) and risking exposure to HIV, some schools have revisited their policy regarding student access to condoms through the SBHC. This chapter describes condom availability programs that operate in SBHCs, as well as more general characteristics of SBHCs, including the services they provide, their funding sources and their staffing patterns. It also takes a closer look at three cities – Baltimore, Maryland; Portland, Oregon and Chicago, Illinois – with strong school-based adolescent health programs. Through leadership from the public health department and broad-based community support, Baltimore and Portland centers have recently expanded services to include condom availability. From their beginning, health centers administered by the Ounce of Prevention Fund of Chicago have provided condoms and other family planning services as an important component of comprehensive primary care services.

The Center for Population Options (CPO) gathered this information through a survey of SBHCs that offer access to condoms. Forty health centers completed a questionnaire concerning available services, policy and client population. Twenty-seven provided CPO with more detailed information on their condom availability programs through a telephone interview.

Results from this survey and the subsequent case studies reveal how condom availability programs function within the context of comprehensive health services provided by SBHCs.

I. CHARACTERISTICS OF SBHC CONDOM AVAILABILITY PROGRAMS

Condoms may be made available at junior high, middle or even elementary school health centers if the community, policy makers, students and educators deem it advisable, but programs are usually conducted in senior high schools as part of HIV/AIDS and teen pregnancy prevention efforts.

A policy of condom availability may be initiated for a number of reasons: SBHC staff identifying high levels of STDs; students finding condoms inaccessible; parents, school board members, or community professionals wishing to prevent adolescent HIV transmission.

In the majority of SBHCs surveyed, center staff or the local health department provided the initial leadership and source of support for the policy. However, leadership has come from other sources as well: parents; school boards; community-based organizations; the school administration; students and state or local governments.

LEADERSHIP FOR INITIATING CONDOM AVAILABILITY IN SBHCS (N = 39)

	Percent	*Number of SBHCs*
SBHC sponsor or staff	26%	10
Local health department	20%	8
Other local government	10%	4
Parents	10%	4
School boards	8%	3
Community-based organizations	8%	3
School administration	8%	3
State agency	5%	2
Students	5%	2

A. Purpose

Many SBHCs hope to reduce or prevent high rates of teen pregnancy, HIV and other STDs through condom availability. Sixty percent of responding centers indicated that a high teen pregnancy rate was an impetus for their condom availability program. Thirty-eight percent responded that high rates of sexual activity influenced the decision to begin condom availability. Twenty-five percent included high rates of HIV/AIDS or other STDs as a motivation for implementing condom availability programs. Condom availability programs are often components of a larger health education effort. Almost two-thirds of schools surveyed already had a comprehensive HIV prevention or sexuality education program. Most of the remaining schools are planning to implement such a program.

Few SBHCs conducted a formal needs assessment on the demand for, or the availability and accessibility of, condoms in their community. In response to CPO's survey, eight percent (3) indicated condoms were not available to teens outside the SBHC; 73 percent (29) said condoms were somewhat available. Twenty percent (8) did not know how accessible condoms were for teens in the community. Overall, 55 percent (22) reported they were aware of other low- cost/ free sources for condoms in their communities, usually from community centers or health agencies. Sometimes these programs were formally linked with their SBHC.

REASONS FOR IMPLEMENTING CONDOM AVAILABILITY PROGRAM IN SBHCS (N = 40)

	Percent*	Number of SBHCs
High teen pregnancy rate	60%	24
High sexual activity rate	38%	15
High HIV/AIDS/STD rate	25%	10
Other	5%	2

*Totals are more than 100 percent because some SBHCs gave more than one reason for implementing the program.

B. Administration

Generally, condom availability is administered as part of regular health center services, although some SBHCs participate in a district- or city-wide program to make condoms available to students.

Responding SBHCs report that condoms have been available from two to 14 years, with a mean of 5.5 years. Two-thirds of the programs have been in place six or fewer years. The great majority (87 percent) of centers made condoms available during service hours, five days per week. Only one health center reported being open on Saturday. On average, condoms were available Monday through Friday, approximately eight hours per day.

When schools are closed for extended periods of time, such as summer and holiday vacations, many centers continue their services, including condom availability. Seventy-five percent of SBHCs surveyed were open during the summer; 60 percent operated during teacher workdays and in-service days, and 48 percent were open during school holidays.

C. Participation

Most SBHCs require clients to be enrolled in order to receive certain services. Enrollment usually means the student has a parental consent form on file. Some services – such as access to condoms – may be available to individuals who are not enrolled. Over one-third of centers surveyed limited access to condoms to enrolled students. Some programs provided condoms to any student in the school, and others made condoms available more widely. Among the non-student populations served were students' siblings, area adolescents, out of school youth and faculty and staff.

POPULATION SERVED BY SBHC CONDOM AVAILABILITY PROGRAMS (N = 27)

	Percentages	Number of SBHCs
Students enrolled in SBHC	100%	27
Children of students	41%	11
Students not enrolled in SBHC	22%	6
Students not enrolled in base school	22%	6
Any adolescent in area	15%	4
Out-of-school youth	11%	3
Students' siblings	11%	3
Teachers and staff	7%	2

D. Condom Availability Location

Most centers reported that condoms were available at their site, in the school nurse's office, through grab bags, in specific classrooms or at more than one site. The table below indicates the point(s) of availability at the 40 SBHC programs surveyed.

LOCATION OF CONDOM AVAILABILITY IN SBHC SCHOOLS (N = 40)

Site	Percent*	Number SBHCs
SBHC	85%	34
Nurse's office	10%	3
Classroom	5%	2
Baskets or grab bags	5%	2
Vending machines	0%	0
Other	15%	6

*Total is more than 100 percent because some sites make condoms available at more than one location.

Thirty-five health centers reported the number of condoms provided per visit ranged from two to 48 with an average of 9.5. The total number of condoms dispensed by the program varied depending on the size of the school and the design of the program. Twenty-six centers dispensed from 10 to 5,000 condoms each in an average month, the average number per SBHC being 2,074 per month. The median used per month was 1,824 per school program.

E. Staffing

SBHCs are usually staffed by a number of medical and psychosocial professionals, many of whom are well trained in areas of adolescent sexuality. Forty percent of the SBHCs surveyed, however, required additional training for staff involved in condom availability. The most prevalent topics were the AIDS epidemic and HIV infection, other STDs and pregnancy prevention. Fewer centers train staff to communicate with teens or educate teens on condom use. Training is usually provided by city, county or state health departments, although center staff and outside trainers may also be used.

F. Counseling and Education

Counseling and education are important functions of any school-based health center. Health education concerning HIV, STDs, pregnancy, sexuality and condom use should be included in a comprehensive condom availability program and can be delivered in the center and/or in the classroom.

Seventy-two percent of the SBHCs responding reported a counseling requirement for students to obtain condoms. Of the 12 SBHCs that did not require counseling in order for students to acquire condoms through the program, 66.7 percent (8) reported counseling was available. Sixty-five percent (26) of all SBHCs surveyed reported that, when a student makes a return visit, they attempt to assess whether the student was using condoms properly.

All health centers that made condoms available provide information and/or counseling on their use, and a majority were involved in HIV/AIDS and sexuality education in the classroom. The table below indicates the type of counseling and education available, and who provided it in the schools surveyed.

COUNSELING AND EDUCATION SERVICES PROVIDED IN SBHCS WITH CONDOM AVAILABILITY (N = 27)

	SBHC Provided	*Health Center & School Provided*	*School Provided*
Information and/or counseling on condom use	100% (27)		
AIDS education	100% (27)		
HIV counseling	78% (21)	4% (1)	
Sexuality counseling	67% (18)	30% (8)	
AIDS education in classroom	59% (16)	30% (8)	11% (3)
Sex education in classroom	59% (16)	30% (8)	7% (2)

G. *Family Planning Services*

Many condom availability programs are part of comprehensive family planning services provided at an SBHC. While it is not necessary to provide comprehensive services to provide condoms, it is apparent from the table below that many of the SBHCs in this survey do.

FAMILY PLANNING SERVICES PROVIDED IN SBHCS (N = 27)

	SBHC Providing
Condoms	100% (27)
Counseling for birth control methods	100% (27)
Follow-up on contraceptive use	100% (27)
Pregnancy tests	100% (27)
Examinations for birth control methods	93% (25)
Spermicidal foam	93% (25)
Referrals for counseling & other family planning services	89% (24)
Prescriptions for birth control pills	78% (21)
Referrals for contraceptives	74% (20)
Other contraceptives dispensed	74% (20)
Other contraceptives prescribed	37% (10)

H. *Sources for Condoms*

The SBHCs surveyed dispense an average of approximately 2,000 condoms per month. These condoms may be purchased from a condom distributor or health agency, although many SBHCs receive condoms free. The most common source of donated condoms is the health department (67 percent of centers responding); however, they also may be provided by the manufacturer or another agency. The source for condoms may differ from that of other contraceptives.

SOURCES FOR CONDOMS IN SBHCS (N = 40)

Source for Condoms	*In-Kind donation**	*Purchased**
Health department	67% (27)	8 % (3)
Manufacturer	0% (0)	12.5% (5)
Outside agency	10% (4)	10 % (4)

*Total is more than 100 percent because some SBHCs have more than one source for condoms.

I. Funding Sources for Condom Availability and Family Planning Programs

In many cases, condom availability programs are funded as one component of a larger family planning program. The majority of the SBHCs surveyed (90 percent) receive either funding or condoms from state health organizations or city/county governments. State and city/county health organizations are also the primary sources of funding for family planning services, with 72 percent of centers citing them as funding sources. About one-fourth of centers reported two or more sources of funding for their condom availability programs. Six centers reported two or more sources of funding for their family planning services. Many used the same funds to operate both programs. Only one center reported that it required fees for condoms and family planning services from its clients.

FUNDING SOURCES FOR SBHC CONDOM AVAILABILITY AND FAMILY PLANNING PROGRAMS, SBHCS WITH CONDOM AVAILABILITY PROGRAMS (N = 40)

	Condom Availability*	Family Planning*
State health department	50% (20)	45% (18)
City/county government	40% (16)	35% (14)
Private foundation	18% (7)	13% (5)
Community health center	15% (6)	13% (5)
Patient fees	5% (2)	7% (3)
Matching block grant	5% (2)	5% (2)
Title X	5% (2)	3% (1)
Private insurance reimbursement	5% (2)	3% (1)
School district	0%	0%

*Percentages total more than 100 percent because of multiple funding sources.

J. Community Support

The overwhelming majority (96 percent) of the 40 centers surveyed reported that their condom availability programs had "more popular support" than opposition in their communities. The same majority also reported that condom availability programs had "more parental support" than opposition. Of centers responding, 86 percent reported conflicts had been resolved in their communities. Of the five centers reporting that controversy was not resolved, three reported either a specific group that opposed the condom availability program (such as the local PTA) or an individual event that brought negative attention to the program (such as a newspaper column). Twelve centers (30 percent) expected some form of controversy to reoccur.

CPO also asked if there had been attempts to expand or restrict operations or funding through policy action in either 1990-91 or 1991-92. Of 40 SBHCs, only 8 percent (3) said funding restrictions were placed on the condom availability program. Only one center reported that policy restricted family planning or condom availability for the 1990-91 and 1991-92 school years.

K. Evaluation

Given that SBHCs with condom availability programs dispense an average of over 2,000 condoms per month, it is evident students use the service. More detailed evaluation, however, is needed to assess impact. Only 10 percent (4) of the SBHCs surveyed had an evaluation component as part of their program. Of the 36 centers that had not evaluated their programs, 33 percent (12) were planning an evaluation.

II. SBHCS WITH CONDOM AVAILABILITY: GENERAL INFORMATION

A. Demographics of Schools with SBHC Condom Availability Programs

The 27 health centers responding to CPO's telephone survey reported that the population of the schools served ranged from just over 300 students to approximately 10,000 students. The average number of students in schools connected with responding centers was 1,929. Over two-thirds of the centers served schools with more than 1,000 students and one-fifth served schools with more than 2,000 students.

The racial and ethnic composition of the schools where an SBHC with a condom availability program exists is similar to the demographics of populations of schools with SBHCs nationwide. The table below examines the demographics of the populations of schools served by SBHCs, schools served by SBHCs that offer condom availability, and the overall U.S. school population.

COMPARISON OF POPULATIONS OF SCHOOLS WITH SBHCS, SCHOOLS WITH SBHCS OFFERING CONDOM AVAILABILITY AND U.S. TOTAL SCHOOL POPULATION

	Schools with SBHCs	*Schools with SBHCs and Condom Availability*	*U.S. K-12 Total**
White	29%	27.8%	68.8%
African-American, Non-Hispanic	42%	51.6%	15.7%
Hispanic	24%	13.3%	11.2%
Asian/Pacific Islander	2%	4.6%	3.4%
Other/Native American	3%	2.9%*	0.9%

*Source: U.S. Bureau of Census, 1990 Figures. Includes all K-12 public/private enrollment.

B. SBHC Enrollment

School-based health centers provide care for students enrolled in their programs. These students may attend the school where the center is based or attend other schools linked to the health center. Many SBHCs provide services not only for students within their schools but for students' siblings and children, teachers and staff.

Students are enrolled in a SBHC by their parents, who must sign a consent form permitting the child to receive services. Eighteen centers provided CPO with figures indicating the number of students enrolled. Enrollment in SBHCs with condom availability ranged from 259 to 2,782, with an average of 981 enrollees. Twenty-five SBHCs provided figures for total users ranging from 266 to 2,748, with an average of 775. Twenty-five schools also provided figures for total visits per year, with a range of 488 to 8,428 and an average of 2,889.

C. Insurance Coverage of Population Served

Many SBHCs serve students who have little access to private insurance. Twenty health centers with condom availability provided information on the insurance coverage of the students they serve. All reported that at least 20 percent of their students had no insurance coverage; only three centers reported that more than one-third of their students had private insurance, and 15 of the 18 responding centers reported that 20 to 50 percent of their enrollees had coverage under Medicaid or an equivalent program. The table below displays the averages for the types of insurance coverage reported by the 18 SBHCs.

AVERAGE PERCENTAGE OF STUDENTS WITH MEDICAL COVERAGE (N = 40)

No insurance	43%
Medicaid or equivalent	36%
Private insurance	19%

(Sum does not add to 100 percent due to rounding.)

D. Location of SBHCs with Condom Availability Programs

School-based health centers can be located on or near school grounds. The location may be a function of available space, school policy, or a health center sponsor's decision. Of the 27 SBHCs responding, the great majority were school-based (85 percent) as opposed to school-linked (15 percent). Several of the school-based centers were linked to other school populations as well as their own. As expected, the majority (77 percent) served senior high schools. A smaller number served junior high schools or middle/junior high school populations or combination junior high/elementary schools.

E. Other Available Services

Health centers provide a variety of services for their clients, ranging from sports physicals to prenatal care. Condom availability is usually only one component of a comprehensive program. The table below displays the services provided by the 27 responding health centers.

SERVICES OFFERED WITH CONDOM AVAILABILITY (N = 27)

Services Offered	Percentage	Number of SBHCs
General primary care	100%	27
Routine or sports physicals	100%	27
Lab tests	100%	27
Immunizations	100%	27
Dispensed medications	100%	27
Diagnosis and treatment of minor injuries	96%	26
Chronic illness management	96%	26
Diagnosis and treatment of STDs	96%	26
Assessments and referrals to private physicians	93%	25
Prescription for medicine	81%	22
Referral for prenatal care	81%	22
EPSDT screenings	78%	21
Prenatal care	52%	14
HIV testing	44%	12
Pediatric care	37%	11
Dental services	7%	2

F. Hours of Service Delivery

School hours and operating hours for the SBHC closely correspond. Most of the health centers indicated that services are available eight hours a day, Monday through Friday. Only one health center was open on Saturdays, for four hours on alternating weeks.

G. Parental Consent

Most SBHCs require some type of signed parental consent form for the student to receive services. The most prevalent type of parental consent lists all services provided by the health center; parental signature indicates permission for students to receive all services. Most forms also contain a notice that the student may receive certain services, such as treatment of STDs, without parental consent, as mandated by state law.

Responding SBHCs also report that they use different consent forms for some services. For example, consent for the student to receive general services at the SBHC may be separate from consent for HIV testing. Many SBHCs have a policy that once a student has a signed consent form on record, then he or she is eligible to receive services for the duration of his or her enrollment in that school.

H. Sponsoring Agencies

SBHCs are sponsored by a number of state and local agencies. The CPO survey indicates that SBHCs with condom availability programs are most often supported by public health organizations. Overall, this support, as demonstrated by funding, is solid; of responding health centers, 85 percent reported their funding is committed beyond the current fiscal year.

AGENCIES SPONSORING SBHCS WITH CONDOM AVAILABILITY (N = 27)

Sponsoring Agencies	*Percentage*	*Number of SBHCs*
Public health department	63%	17
Community health clinic	11%	3
Community-based organization	4%	1
Hospital/medical school		
Adolescent health department	7%	2
Pediatrics	0%	0
Family practice	4%	1
School system	4%	1
Other	15%	4

*Percentages total more than 100 percent because some SBHCs have multiple sponsors.

III. CASE STUDIES OF EXISTING SBHCS WITH CONDOM AVAILABILITY

The following case studies examine the policies and procedures of school-based health centers where condoms have been made available.

A. Baltimore, Maryland: Case Study of a City Program

In 1985, the City of Baltimore recognized that despite the activities of several pilot projects in the area, health care for many adolescents remained inadequate. Young males, in particular, often seek health care services in STD clinics or emergency rooms, while young females often seek primary care in family planning or prenatal clinics. The opportunity to expand services came through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program's funding for case management, which the Baltimore City Health Department (BCHD) used to begin a Comprehensive School Health Services Program.

Baltimore now supports eight SBHCs and two clinics sponsored by community health centers, to provide health services to in-school youth, and to address inadequate preventive health services for local adolescents.[1]

Goals for Comprehensive School Health Services Program:

- Improve access to preventive and primary health care for adolescents in the program schools.
- Promote positive health behaviors, including primary prevention and early detection of risk-taking behaviors.
- Increase health knowledge and enhance decision-making skills.

Chronology

1985. Mayor's Task Force on Adolescent Pregnancy Prevention issues recommendations for school-related health care delivery program. Seven SBHCs open.

1985-1990. Vouchers for contraceptives are made available.

December 1989. Mayor's Council on Adolescent Pregnancy endorses reproductive health services, including contraceptives, for all young people in Baltimore City. Council recommends linking school-based and neighborhood clinics and all middle, junior and senior high schools.

Spring 1990. Eighth SBHC opens.

Parents of SBHC enrollees are surveyed on attitudes toward contraceptive availability in centers.

Fall 1990. Authority to dispense contraceptives is granted.

September 1990. Contraceptive availability policy is implemented.

Community Involvement in Expansion of Service

The cooperation of local government and local communities, through the SBHC advisory board and parents of school-aged children, played a significant role in changing the policy to make contraceptives available in Baltimore SBHCs. In 1989, the BCHD surveyed a sample of 262 parents of SBHC enrollees by telephone regarding their attitudes toward the center, its services, quality of care and contraceptive distribution. These attitudes were important in shaping Baltimore's policy.

Overall, parents accepted the SBHC program in their local schools. Ninety-four percent of parents interviewed thought that the centers should offer counseling about abstinence, while three percent disapproved and three percent responded that they did not know. Ninety-six percent of parents supported counseling about family planning/pregnancy, with only three percent who disapproved and two percent who responded that they did not know.

Forty-five percent of the parents interviewed had previously communicated, usually by telephone, with the SBHC staff. Fifty-seven percent rated the quality of care at the centers as excellent or very good, 11 percent rated the quality as good, and only one parent felt that the quality of care was poor; 32 percent of the parents interviewed were unable to rate the quality of care. (The survey questions and results can be found in Attachments III.A.1 and 2, respectively.)

Based on the results of this survey, the contraceptive availability program in the Baltimore schools was implemented in September 1990, with counseling and appropriate medical care as a prerequisite for students receiving this service. The efforts of the program administrators in Baltimore provide an excellent example of working with the community to enhance the success of the program.

Several specific aspects of the Comprehensive School Health Services Program with the contraceptive availability component have particularly enhanced its success:

- The comprehensive program was established specifically to address the primary health care needs of in-school youth in Baltimore, with an emphasis on primary prevention.
- The program was established by the local health department, with support from the mayor's task force and city commissioners.
- Parents were involved prior to the establishment of contraceptive availability, and their support rendered the program implementation relatively free of community controversy.
- Each primary health care center functions as a component of the city-wide program, now active in eight schools.

Through these mechanisms, Baltimore's program has achieved the support and enthusiasm of the local community, providing an environment in which the primary health care program can more effectively meet its goals.

General Description of the Program

Most SBHCs in Baltimore are staffed by:

Full Time:	*Part Time:*
Nurse Practitioner or Physician Assistant	Physician
School Nurse	Other Nurse Practitioners
Mental Health Counselor	Substance Abuse Counselors
Medical Office Assistant	Case Managers
Health Aide	Nutritionists

Training Staff Members

The city health department provides professional training on HIV/AIDS, STDs and pregnancy prevention to center staff involved with the program. In general, personnel are required to have previous adolescent health training and experience.

Students With Insurance (1989)

Medicaid:	33%
Hospital insurance:	27%
No health insurance:	40%

SBHC Enrollment and Visitation

Enrollment:	65%	(1990-91)
Total number enrolled:	4,908	(1990-91)
Approximate number visits:	13,581	(1989-90)
Percentage of enrollees who used the centers:	71%	(1990-91)
Percentage of visits for family planning:	9%	(1989-90)

Requirements for Student Participation

Parents are asked to sign a consent form that lists all services provided by the center; a signature indicates permission for the student to receive any services listed. Students may also receive confidential services without parental consent, including diagnosis and treatment for STDs and pregnancy-related care, per state law.

Number of Parents Declining Consent

These data are not available; some parents do not return the form for enrollment because they wish to use only private medical services.

Fees

Fees are assessed to parents for non-confidential services, per state guidelines.

Services Provided in the Primary Health Care Centers

- General primary care
- Annual comprehensive health assessments
- Sports physicals
- Laboratory tests
- Chronic illness management
- Gynecological examinations
- Immunizations
- EPSDT screenings
- Prescriptions
- Dispensation of medications
- Referrals for prenatal care
- Diagnosis and treatment of STDs
- Diagnosis and treatment of minor injuries
- Assessments and referrals to the community health care system and to private local physicians

Counseling/education services

- Sexuality education in the classroom setting
- Sexuality counseling
- HIV counseling
- Information or counseling on condom use
- AIDS education in the classroom
- AIDS education in the SBHC

Family planning services

- Birth control counseling
- Examinations for birth control dispensation
- Condom, foam and oral contraceptive dispensation
- Birth control pill prescriptions
- Contraceptive referrals
- Follow-up on contraceptive use
- Counseling referrals
- Pregnancy tests

Requirements for Participation in Contraceptive (Condom) Availability Program

- Students must be enrolled in the school served by the center.
- Enrollment in the primary health care center is not necessary.
- Students must come in for counseling in conjunction with the initial visit for contraception.

Availability of Condoms and Counseling

Condoms are available during each school's SBHC hours and one day a week during the summer vacation. Counseling and condoms are provided by the school nurse, health center nurse practitioners, health center aides and city health department personnel.

Compliance

Staff assess student's use of condoms during regular follow-up consultations.

Number of Condoms Available Per Visit

If a student requests condoms, he or she can receive up to 10 per visit. The total number of condoms used by the program for the 1990-91 school year was 21,930.

Cost of Condoms

The state health department provides condoms for the Baltimore SBHCs at no cost to the city.

Parent Survey

BALTIMORE, MARYLAND

Instructions for Phone Survey of Parents - SBC schools

1. Student demographics (can be obtained from alpha list)
   School_____
   Grade_____
   Age_____
   Race_____

   Ask to speak to the parent or guardian of _____.
   (read from alpha list)

Hello my name is _____. I'm working with the school health program at _____ school. I would like to ask some questions to the adult who usually takes (first name) to the doctor or who knows the most about his/her health.

2. Who is that person? (relationship to student)
   - o Mother
   - o Father
   - o Stepmother
   - o Stepfather
   - o Grandmother
   - o Others (specify)_____

3. Are you that person?
   - o Yes
   - o No

(If you are not talking to the adult who takes responsibility for the student's health care, ask if they are available to come to the phone.)

If that person is not home:
When would be a good time to call back? ___ _____
Phone Number?_____

(When you have the appropriate person on the phone):

I would like to ask you a few questions about the school health program at _____ school. All of your answers will be strictly confidential. When we prepare our report no names will be used. Your answers will help us evaluate and plan for the school health program at your son's/daughter's school.

4. Do you have time to answer a few questions?
   - o Yes
   - o No

(If no, ask if there is a more convenient time to call back?)
Time _____ Phone number ___-_____

5. Have you ever talked with any member of the school health staff?
   - o Yes
   - o No
   - o don't know (unsure)

6. What things do you like about the school health clinic? (check all that are mentioned, Do Not Read The List)
   - o everything
   - o nothing
   - o don't know
   - o informative/educational
   - o convenience
   - o prompt care
   - o communicates with parents
   - o attentive to concerns and needs of students
   - o particular services
   - o other_____

7. What things don't you like about the school health clinic? (check all that are mentioned, Do Not Read The List)
   - o Nothing
   - o Misdiagnosis
   - o Don't know
   - o Other_____

8. I would like to know what you think about the school clinic. For each of the things I mention, please tell me if you think they are excellent, very good, satisfactory, poor, very poor, or you don't know.

How would you rate the:

a.	quality of care	o	o	o	o	o	o
b.	staff (nurse, NP Drs.)	o	o	o	o	o	o
c.	the way that staff communicates with parents	o	o	o	o	o	o
d.	the way staff communicates with students	o	o	o	o	o	o
e.	conditions in the health suites	o	o	o	o	o	o
f.	overall rating	o	o	o	o	o	o

John Santelli. *Instructions for Phone Survey of Parents -- School-Based Clinic Schools.* Baltimore, MD: Comprehensive School Health Services Program, 1990. Reprinted with permission.

9. I'm going to read a list of services. Please tell me if you think that these should be offered in a school health clinic.

	Yes	No	Don't know
a. Annual/Sport physical	o	o	o
b. Counseling for drug and alcohol abuse	o	o	o
c. Counseling about not having sex or saying "no" to sex	o	o	o
d. Counseling about family planning/pregnancy	o	o	o
e. Family planning for sexually active teens	o	o	o
f. Treatment for sexually transmitted diseases	o	o	o
g. Counseling for emotional problems	o	o	o

10. Do you think the school clinic should provide parents with information on health topics?

o Yes
o No
o Don't Know

11. If yes, what topics would you find helpful? (check all that are mentioned, do not read the list. If respondent is having trouble answering this question try asking What health topics are important in your family? To other families in your neighborhood? What are the important health concerns for your teenager?

o General health issues
o AIDS
o Nutrition/Diet
o Learning problems
o Communicating with children
o Drugs and alcohol
o Smoking
o Protecting children from sexual abuse
o Preventing violence
o Helping teenagers make decisions
o Teenage Pregnancy
o Birth Control
o Hygiene
o Peer Pressure
o Self esteem
o Religion
o other_____

12. Do you think that the school heath clinic should provide parents with information that would help them to talk to their children about human sexuality?

o Yes
o No
o Don't know (undecided)

13. Do you think that school health clinics should provide students with information about human sexuality? (pregnancy, birth control,abstinence, menstruation, values clarification, peer influences and other areas of human sexuality?)

o Yes
o No
o Don't know (undecided)

14. Do you think that school health clinics should provide students with prescriptions for birth control or condoms?

o Yes
o No
o Don't know

15. Do you think that school health clinics should provide students with birth control pills or condoms at the school clinic?

o Yes
o No
o Don't know (undecided)

16. If a boy is already having sex, do you think that the school health clinic should provide him with condoms?

o Yes
o No
o Don't know

17. If a girl is already having sex, do you think that the school health clinic should provide her with birth control pills or condoms?

o Yes
o No
o Don't know

18. If <u>your child</u> is already having sex, do you think that the school health clinic should provide him/her with birth control pills or condoms?

o Yes
o No
o Don't know

19. If a parent gives permission, do you think that the school health clinc should provide a student with birth control pills and condoms?

o Yes
o No
o Don't know

20. Would you like to serve on the community advisory board for the school clinic? (If yes, give them a phone number to call the next day.)

21. Do you have any recommendations about the school health program that you would like the principal to hear ?

_____-
_____-
_____-
_____.

Parent Survey Responses

Bringing Parents Into School Clinics: Parent Attitudes Toward School Clinics and Contraception

Table 1. Parents' Rating of Baltimore City School Clinics Expressed as Percentages (n = 262)*

	Excellent	Very good	Satisfactory	Poor or very poor	Don't know
Quality of care	21	36	11	<1	32
Staff (NP, nurse, MD)	23	37	5	0	30
The way staff communicates:					
with parents	22	34	12	2	29
with students	25	39	10	1	25
Condition in the health suite	14	28	13	<1	44
Overall rating	25	36	12	1	27
Overall rating if					
Parent reported prior verbal contact with clinic†	35	37	14	1	13
No prior verbal contact	16	34	10	1	38

*Rows do not total 100% because of rounding.
†Most prior verbal contact represents telephone contact.

Table 2. Parental Acceptance of Contraception through Baltimore City School Clinics Expressed as Percentages (n = 262)*

	Yes	No	Don't know
School Health Clinic should provide			
Students with prescriptions for BCP†/condoms	63	27	10
Students with BCP/condoms at the school clinic	63	30	7
Boys with condoms, if already sexually active	76	14	10
Girls with BCP/condoms, if already sexually active	73	17	7
Your child with BCP/condoms, if already sexually active	70	23	7
Students with BCP/condoms, if parent gives permission	93	3	4

*Rows do not total 100% because of rounding.
†Birth control pills.

Santelli, John, M.D., et al. "Bringing Parents Into School Clinics: Parent Attitudes Toward School Clinics and Contraception," Journal of Adolescent Health. Vol. 13, No. 4, June, 1992. Used with permission.

B. Portland, Oregon: Strategic Planning for Policy Change

There are seven SBHCs in Multnomah County, Oregon, the county in which the city of Portland is located. Five of the centers are supported exclusively with Multnomah County funds and two with funds allocated by the Oregon State Legislature.

Prior to a policy change in Portland in 1992, Oregon Health Division policy stated that SBHCs could not procure or dispense contraceptive materials or devices.

Chronology

1986. First SBHC opens through cooperation of Multnomah County Health Department and Portland Public Schools. An agreement between the two prohibits on-site dispensing of contraceptives.

1987. Three additional SBHCs open.

1988-1989. Three additional SBHCs open.

March 1992. The health department and the Portland School District changes the policy to allow on-site condom availability.

Community Involvement in Service Expansion

From 1986 - 1992 the Health Department built community support for the SBHC program and expanded services through:

- Assessment of the Advocacy Environment
  Identification of individuals and groups likely to support and oppose the proposed policy change, and the themes likely to emerge in public discussion.
- Role of Parents and Community-Based Organizations
  The contraceptive access issue was first raised publicly by parent advocacy groups. The health department was able to remain in the role of supporting a proposal from the community.
- Aggressive Media Campaign
  Spokespeople for the health department and community were identified; two to three primary messages on adolescent health were developed for dissemination through the media; public affairs programming was pursued to increase public understanding of teen health issues. Media outreach was stepped-up prior to release of the survey results.
- Use of Public Opinion Surveys
  A community-wide poll that indicated broad support (60 percent) for on-site condom availability was the basis for the policy change. Public opinion survey results had been used twice previously by the health department before implementing policy changes. In all three instances, the surveys documented support for a controversial program and neutralized the effect of the opposition.

Community debate and an independently conducted opinion poll indicating 60 percent approval for the expanded program enabled the health department and Portland School District to change the policy with minimal conflict.

School District-wide Poll

The school district commissioned a poll to assess community support for a condom availability program as part of school-based health center services. Focus groups were conducted to identify which issues to address in the questions. (Small but adequate sample size surveys can be conducted for $3,000-5,000, or less if there are universities available and willing to conduct public interest work at no cost. Large sample size surveys like the one conducted in Portland can cost up to $25,000.)

A telephone survey was conducted of randomly selected Portland School District adult residents ("adults"), parents and students during January 1992. Interviews were conducted with 300 adults and 750 each of parents and students from lists provided by the District. All responses were calculated to a 95 percent confidence level.

The survey found that SBHCs have wide support in the community. There was more support for making condoms available than for making oral contraceptives available. Residents particularly endorsed a condom availability program intended to prevent the spread of STDs. Residents favored abstinence counseling before a student can acquire a condom. (See Attachment III.B.1 for the survey summary.)

The results of the survey were released with the announcement of health center service expansion to include condom availability. The School Superintendent based his decision, in part, on these results. This process made it easier to represent the public, limit the media furor, neutralize the high-visibility organizing tactics of the religious right and undermine complaints of exclusion by the opposition. After the survey and proposal were released, further opposition died down. (See Attachment III.B.2 for the school's news release and statement, Attachment III.B.3 for editorial response to the announcement.)

Health Center Staff

Each SBHC is staffed by trained professionals experienced in adolescent health care. Staff are hired not only for their technical expertise but for their concern about teenagers' well-being. Centers use a nurse coordinator/nurse practitioner/receptionist staffing model to maximize on-site care.

Consent for Care

According to Oregon law, students age 15 and over may obtain health services without parental consent; however, all centers strongly encourage students to involve their parents in their health care. Each site provides information about its services and sends consent forms to parents.

Oregon statute permits a person of any age to receive family planning or STD treatment without parental consent. Students under age 14 must have parental consent to receive all other center services.

Visitation to All Seven Centers (1990-91)

Total users: 4,223

Total visits: 18,640

Percent of students enrolled using services: 50%

Health Center Hours

Allowing for individual variance, centers are open from approximately 8 a.m. to 4 p.m. every school day. Most programs are closed to students part of one day to allow for meetings, paperwork and planning. Students are seen on both a scheduled and drop-in basis and can access the center on their own or through referrals from teachers, counselors or school nurses. When possible, staff schedule appointments before and after school, or during lunch and break times.

Services Provided (1990-91)

Acute Visits (29 percent of all visits)

- Injuries
- Infections

Non-Acute/Chronic (14 percent of all visits)

- Anemia
- Skin disorders
- Diabetes
- Hypertension

Reproductive Health (32 percent of all visits)

- Menstrual disorders
- Sexually transmitted disease
- Family planning
- Pregnancy tests
- Prenatal care

Mental/Emotional Health (15 percent of all visits)

- Relationship problems
- Depression
- Eating disorders
- Abuse
- Trouble at home

Health Promotion (10 percent of all visits)

- Nutrition
- Smoking cessation
- Health screenings
- Immunizations
- Athletic physicals

C. Chicago, Illinois: Case Study of a Prevention Model

The Ounce of Prevention Fund in Chicago promotes the well-being of children and adolescents, and works with families to reduce the causes of child abuse and neglect. Toward these objectives, the Fund administers adolescent health centers in three public senior high schools in the city of Chicago. The program model incorporates both a comprehensive primary prevention component and an intervention program for parenting teens. Schools were chosen based on a needs assessment examining rates of poverty and teen pregnancy rates as well as available community health care and local interest in a school-based health center. The Fund's complete program, "Toward Teen Health," includes the three adolescent health centers, as well as an educational primary prevention program in seven elementary schools which feed into the three secondary schools.

Primary Program Goals

- Provide comprehensive health care to adolescents in underserved communities.
- Reduce the risk of low birth weight for babies born to teenagers.
- Reduce the risks of adolescent pregnancy and too-early childbearing.

Chronology

1985. First adolescent health center opens.

1986. Second adolescent health center opens.

1987. Third adolescent health center opens.

Adolescent Health Center Staff

Full time:	*Part Time:*
Nurse Practitioner/Site Manager	Physician: minimum three half-days per week
Medical Assistant	Medical Director: shared between three schools
Health Educator	Training Staff Members
Social Worker	Health center staff must have experience and/or training in working with adolescents. The prevention model also incorporates a commitment to periodic in-services, as needed, on issues pertaining to the health of adolescents.
Administrative Assistant	

Requirements for Student Enrollment

Students must be enrolled in the SBHC school. Parents are asked to come to the school and sign a one-time consent form listing all services provided. This gives parents the opportunity to check-off services they do not want their child to receive. A signature indicates permission for students to receive any of the services except those restricted by the parent. The parents may change their form at any time.

Survey Summary

The results of a recent survey of Portland Public School District residents, parents and students revealed that:

- Student health clinics in Portland public high schools are widely embraced by the community at large (85% good idea versus 12% not a good idea) and by parents (83% good idea versus 13% not a good idea). Student health clinics are even more popular with students (93% good idea versus 5% not a good idea). Furthermore, even a majority of residents, parents and students who opposed the distribution of condoms or birth control pills felt it was a good idea to have student health clinics in Portland public high schools.

- The dispensing of condoms by school nurses or nurses at student health clinics is approved by a majority of Portland public school district residents (63% favor versus 32% oppose), parents (60% favor versus 32% oppose) and students (77% favor versus 16% oppose). Condom distribution was favored by parents of students in all ten Portland high schools.

- The dispensing of birth control pills in Portland public high schools is not as popular but is, nevertheless, acceptable to a majority of residents (52% favor versus 43% oppose), parents (50% favor versus 41% oppose) and students (64% favor versus 25% oppose). Interestingly, residents under age 55 embrace the dispensing of contraceptives in Portland public high schools, but residents over 55 are opposed to such distribution.

- The distribution of contraceptives to help prevent the spread of sexually transmitted diseases like gonorrhea, syphillis and AIDS is strongly endorsed by residents (72% favor), parents (72% favor) and students (89% favor). Requiring students to seek abstinence counseling before they receive contraceptives is equally important to parents (71% favor) and more important to them than to either residents at large (63% favor) or students (62% favor). Other considerations related to the distribution of contraceptives that resonate favorably with both residents at large and parents are the realization that users of student health clinics in Multnomah County experience a lower birth rate than non-users in the county (66% residents, 68% parents) and that a majority of students seeking family planning services from school based health centers have been sexually active for some time (64% residents, 67% parents).

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- Requiring parental approval before a student could receive condoms or birth control pills was more problematic to both residents at large and parents of students in Portland public high schools. For residents at large, the parental approval requirement evenly divided the community for (46%) and against (48%). A majority of parents (52%) endorsed the parental approval requirement, while over four-in-ten (42%) opposed it. Interestingly, the parental consent requirement diminishes the support of some who favor contraceptive distribution and increases the support of some who oppose dispensing of contraceptives. Some supporters apparently don't want parents involved, while some opponents believe parental involvement justifies distribution.

- In another question about parental consent that tests the conditions under which parents should be notified before students receive condoms or birth control pills, a plurality of parents (49%) believe there were some cases in which parents should not be notified. Over four-in-ten (43%) thought parents should always be notified before students were given condoms or birth control pills.

- Finally, in the opinion of residents at large, the effect of distributing condoms will be to increase students personal sexual responsibility (52% increase, 32% no difference). Parents are slightly less convinced that the distribution of condoms will increase personal sexual responsibility, but they nevertheless agree (45% increase, 33% no difference). With regard to the effect distributing condoms would have on the rate of pregnancy and sexually transmitted diseases, both residents (68%) and parents (62%) think it will decrease. At the same time, community residents (64%) and parents (62%) think the sexual activity among Portland's high school students will not be affected by the distribution of condoms.

News Release and Statement

PORTLAND PUBLIC SCHOOLS
NEWS SERVICE
Department of Public Information & Communication / 501 N. Dixon St. / Portland OR 97227/(503) 249-3304

FOR RELEASE: IMMEDIATE	DATE: February 10, 1992	NUMBER: 059

Prophet Approves Providing Condoms in Portland High Schools

Schools Supt. Matthew Prophet announced today that health professionals will provide condoms at six of Portland's High Schools.

"There is an urgent need to protect our children from AIDS and other sexually transmitted diseases", Prophet said in announcing his decision that health officials will provide condoms on campus.

Teen health centers at Roosevelt, Cleveland, Marshall, Madison, Jefferson, and Grant high schools soon will begin dispensing condoms to students following abstinence counseling, Prophet said.

Prophet also released the results of a public opinion poll which showed parents, by a 2--1 margin, favored dispensing condoms in Portland high schools. The independent survey was commissioned by Prophet to advise him on whether parents wanted health workers to be able to give their children condoms at school. The poll results show residents and students also favor by wide margins dispensing condoms in high schools.

"Portland parents and the community have spoken," said Prophet. "We now are responding to their wishes."

A scientifically random telephone survey, conducted by Moore Information, Inc., polled 750 parents, 750 students and 300 adult residents between Jan. 27-31.

(Over)

Currently, six Portland high schools have teen health centers that prescribe condoms. Students can redeem the prescriptions at off-campus pharmacies. But Multnomah County and health officials, who operate the centers had asked Prophet to let them give condoms to students directly because many prescriptions go unfilled. The survey found that the community at large, parents and students, widely supported the existence of student health centers in the high schools and provide condoms to students at the clinics.

The Portland school District began taking steps to reach a decision on dispensing condoms after basketball star Magic Johnson announced in November that he had contracted the virus that causes acquired immune deficiency syndrome.

For Further information, please contact: Bill Garbett, director, Dept. of Public Information and Communication, Portland Public Schools, 249-3304

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CONDOM DISTRIBUTION STATEMENT

By: Matthew W. Prophet
Superintendent
Portland Public Schools

February 10, 1992

GOOD MORNING. AS SUPERINTENDENT OF PORTLAND PUBLIC SCHOOLS, I HAVE CALLED A NEWS CONFERENCE TO ANNOUNCE MY DECISION REGARDING THE URGENT NEED TO PROTECT OUR CHILDREN FROM AIDS AND OTHER SEXUALLY TRANSMITTED DISEASES AND WHETHER TO SUPPORT A REQUEST FROM MULTNOMAH COUNTY TO MODIFY THE LANGUAGE IN A CURRENT AGREEMENT DEALING WITH THE OPERATION OF TEEN HEALTH CENTERS.

MULTNOMAH COUNTY HAS RECOMMENDED THAT THE LANGUAGE IN OUR CURRENT AGREEMENT BE CHANGED FROM PERMITTING ONLY THE PRESCRIBING OF CONDOMS AND CONTRACEPTIVES IN OUR HEALTH CLINICS, TO ONE WHICH WOULD ALSO PERMIT THE ACTUAL DISPENSING OF CONDOMS AND CONTRACEPTIVES IN OUR HEALTH CLINICS TO STUDENTS UNDER APPROPRIATE MEDICAL SUPERVISION.

IN OUR SCHOOL BASED HEALTH CENTERS, MULTNOMAH COUNTY CURRENTLY PROVIDES COMPREHENSIVE PRIMARY CARE SERVICES INCLUDING:

1) COMPREHENSIVE ABSTINENCE COUNSELING,

2) DIAGNOSIS AND TREATMENT OF SEXUALLY TRANSMITTED DISEASES,

3) TREATMENT FOR MENSTRUAL DISORDERS; AND,

4) ON SITE COUNSELING FOR AND PRESCRIBING OF OTHER CONTRACEPTIVES.

MULTNOMAH COUNTY HAS BROUGHT OUR ATTENTION TO SOME VERY DISTURBING FACTS. THEY HAVE FOR EXAMPLE INFORMED US THAT:

- NATIONALLY THE NUMBER OF AIDS CASES IN TEENAGERS HAS INCREASED 40% SINCE 1987; AND,
- THAT IN OREGON IN 1989 14% OF NEW SYPHILIS CASES WERE AMONG 15-19 YEAR OLDS,
- 28% OF NEW GONORRHEA CASES WERE AMONG 15 TO 19 YEAR OLDS.
- 42% OF NEW CHLAMYDIA CASES WERE AMONG 15 TO 19 YEAR OLDS; AND FINALLY,
- 19% OF MULTNOMAH COUNTY AIDS CASES OCCURRED AMONG INDIVIDUALS 20 TO 29 YEARS OLD AND THAT DUE TO THE 7 TO 10 YEAR DELAY BETWEEN EXPOSURE AND DIAGNOSIS, AIDS RESEARCHES BELIEVE A HIGH PERCENTAGES OF THAT GROUP CONTRACTED THE DISEASE AS TEENAGERS.

THEREFORE, BECAUSE OF THESE VERY SURPRISING AND ALARMING STATISTICS, AND DUE TO THE COUNTY'S REQUEST TO MODIFY THE AGREEMENT IN A WAY WHICH COUNTY MEDICAL AUTHORITIES FEEL WOULD PROVIDE IMPROVED PROTECTION TO OUR STUDENTS FROM SEXUALLY TRANSMITTED DISEASES, I FELT I NEEDED THE INPUT AND OPINION ON THESE MATTERS FROM OUR PARENTS, OUR COMMUNITY AND OUR STUDENTS, TO HELP ME FORM MY OWN OPINIONS AND TO MAKE A DECISION AS TO WHETHER TO SUPPORT OR NOT SUPPORT THE REQUEST FROM MULTNOMAH COUNTY.

ALSO, BECAUSE OF THE VARIOUS MORAL AND ETHICAL CONSIDERATIONS, AND OTHER VERY CHALLENGING COMPLICATIONS THAT ARISE WHEN ONE DEALS WITH ISSUES OF THIS KIND, I FELT IT WAS IMPORTANT TO CONDUCT A RELIABLE AND SCIENTIFIC SURVEY OF PARENTS, CITIZENS AND STUDENTS WITH THE SURVEY TO BE CONDUCTED BY AN INDEPENDENT RESEARCH FIRM. I WOULD NOW LIKE TO ASK BOB MOORE, THE PRINCIPAL RESEARCHER IN THIS EFFORT, TO REPORT HIS FINDINGS TO YOU.

INTRODUCE MR. MOORE. –

THANK YOU MR. MOORE.

THE TIMES IN WHICH WE LIVE REQUIRE RESPONSIBLE DECISION MAKING AND, I BELIEVE THAT THE PROCESS WE HAVE UNDERTAKEN IS FAIR AND IT IS OBJECTIVE. IN THE DECISION I AM ABOUT TO ANNOUNCE, EVERYONE MUST KNOW THAT IN ADDITION TO MR. MOORE'S RESEARCH FINDINGS, MY DECISION ALSO REFLECTS AND TAKES INTO CONSIDERATION, OTHER INPUT COMING FROM CLINIC ADVISORY COMMITTEES AT THE SCHOOLS, COUNTY AND STATE HEALTH DEPARTMENTS, PHONE CALLS AND LETTERS TO THE DISTRICT, INPUT FROM THE RELIGIOUS COMMUNITY, EDITORIAL VIEWS EXPRESSED BY OUR LOCAL MEDIA, PROCESSES AND OUTCOMES IN OTHER CITIES WHO ARE DEALING WITH THIS ISSUE, AND CERTAINLY, MY OWN KNOWLEDGE OF WHAT IS REALLY HAPPENING WITH OUR CHILDREN.

I HAVE DECIDED TO SUPPORT THE HEALTH OFFICIALS' REQUEST TO PROVIDE CONDOMS IN THE SIX HIGH SCHOOL HEALTH CLINICS TO STUDENTS UNDER MEDICAL SUPERVISION.

THE SIX SCHOOLS WHERE I SUPPORT THE REQUEST ARE:

- ROOSEVELT
- JEFFERSON
- GRANT
- MARSHALL
- CLEVELAND
- MADISON

MY AGREEMENT WITH THEIR REQUEST IS WITH THE UNDERSTANDING THAT **CONDOMS WILL BE PROVIDED** AND DISPENSED **ONLY** AFTER COMPREHENSIVE **ABSTINENCE COUNSELING** HAS OCCURRED, -- ALONG WITH OTHER STRICT **MEDICAL PROTOCOL** AND PROCEDURES.

MY AGREEMENT WITH HEALTH OFFICIALS IS ALSO GIVEN WITH THE UNDERSTANDING THAT MEDICAL PERSONNEL IN THE SIX TEEN HEALTH CENTERS WILL URGE AND ASSIST ALL STUDENTS TO OBTAIN PARENTAL INVOLVEMENT IN ALL STUDENT HEALTH DECISION. THIS, OF COURSE, IS A PRACTICE WHICH IS CURRENTLY BEING FOLLOWED. **OUR EFFORTS MUST REMAIN VERY VIGOROUS IN THIS AREA.**

IT IS ALSO OF GREAT IMPORTANCE TO REMIND OUR PARENTS AND OUR COMMUNITY THAT IN OUR CLASSROOMS, AS WELL AS THE CLINICS, **ABSTINENCE** IS THE OVERRIDING AND CONSISTENT MESSAGE WE TEACH TO OUR STUDENTS, AND THAT OUR PROGRAM IN HEALTH INSTRUCTION WILL BE CLOSELY MONITORED AND SUPERVISED TO ASSURE THAT OUR STUDENTS LEARN AND UNDERSTAND THAT - **THERE IS NO SUCH THING AS SAFE SEX.**

THE PROVISIONS OF THE NEW AGREEMENT BETWEEN THE COUNTY AND THE SCHOOL DISTRICT WILL BECOME EFFECTIVE AS SOON AS MULTNOMAH COUNTY FINDS IT PRACTICABLE TO IMPLEMENT SAME. THE AGREEMENT CURRENTLY APPLIES ONLY TO THOSE HIGH SCHOOLS WHERE TEEN CLINICS ARE LOCATED AND OPERATING WITH LICENSED HEALTH CARE PROVIDERS.

AT THE FOUR (4) HIGH SCHOOLS WHERE THERE ARE NO TEEN HEALTH CENTERS, HEALTH OFFICIALS AND THE SCHOOL DISTRICT WILL WORK TOWARD THE IMPLEMENTATION OF THIS SERVICE.

IN CLOSING, I WANT TO THANK:

- MULTNOMAH COUNTY OFFICIALS
- ADVISORY BOARD
- CITIZEN SCHOOL ADVISORY COMMITTEES
- CLINIC ADVISORY COMMITTEES
- THE MEDIA
- PARENTS
- CITIZENS
- RELIGIOUS ORGANIZATIONS
- PORTLAND SCHOOL STAFF, AND STUDENTS
- MOORE INFORMATION INCORPORATED

I AM SINCERE IN MY BELIEF THAT WE HAVE ADOPTED A RESONSIBLE PUBLIC HEALTH POLICY AND RESPONDED TO THE EXPRESSED WISHES OF OUR PARENTS AND OUR COMMUNITY. ***PORTLAND PARENTS AND THE COMMUNITY HAVE SPOKEN. WE NOW ARE RESPONDING TO THEIR WISHES.***

THANK YOU.

Editorial Response to Plan

The Oregonian

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WEDNESDAY, FEBRUARY 12, 1992

Condoms not enough

Add birth-control pills to the "safer-sex" services directly distributed by county's teen clinics

Portland School District Superintendent Matthew Prophet's decision to allow county-run health clinics at Portland high schools to distribute free condoms was a wise move.

Health-clinic staffs will tie condom distribution to abstinence counseling that will stress the "no sex is the only truly safe sex" message. The battle against AIDS and other sexually transmitted diseases will be fought the way it should be fought: with all available weapons.

But Prophet's decision against allowing on-site distribution of birth-control pills retains a barrier in the fight against another major public health problem, teen-age pregnancy.

Although other prescriptions written by nurse practitioners are delivered to teens at the student clinics, girls must go off-campus to pick up birth-control pills.

This hypocritical, arm's-length approach costs girls, and society, dearly. Since the girls don't come back to the student health center to pick up their pills, they don't receive the additional advice about how to use birth-control pills and a repeated warning about the risks associated with any sexual activity delivered by their own clinician.

Clinic staffs also have found that many girls don't get their prescriptions filled. Ninety percent of the teens who seek birth-control advice from the student health clinics have been sexually active for at least a year. So it's unlikely those unfilled prescriptions represent a decision to abstain from sex. Rather, they represent girls who face a greater risk of becoming pregnant.

Allowing direct distribution of birth-control pills is not an easy decision. The district's public-opinion survey found that 52 percent of district residents favor pill distribution while 43 percent oppose it. By contrast, 63 percent of residents favored condom distribution while only 32 percent opposed it.

Still, teen-age girls would be better served by direct distribution of birth-control pills. This doesn't mean that parental concerns should be ignored. Parents should be given an opt-out option. They should be allowed to notify the student health clinics in advance that they do not wish their children to receive birth-control services.

Wise parents would exercise that option judiciously, recognizing that protected sex is better than unprotected sex if their children choose to disregard their pleas for abstinence.

The discussion of how best to provide birth-control services to teens shouldn't end with this week's condom decision. The Multnomah County health department and Portland Public Schools will want to revisit the issue periodically.

Other county health departments, school districts and parents also should tackle these questions. The need to prevent teen-age pregnancy and sexually transmitted diseases demands it.

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SBHC Enrollment and Visitation (1990-91)

Enrollment (as a % of student body):	77%
Total number enrolled:	2,674
Approximate number of visits:	6,400
Percentage of enrollees who used the centers:	64%
Percentage of services delivered related to family planning:	19%

Location and Hours

The centers are located in the main school building and are open 8 a.m. through 4 p.m. weekdays, during the summer and teacher in-service days.

Fees

There are no fees charged.

Services Provided by the Adolescent Health Centers

Medical and Other Individual Services

Health Promotion (26 percent of all services)

- Physical examinations
- Psychosocial assessments
- Immunizations

Minor Illness and Injury Diagnosis and Treatment (18 percent of all visits)

Chronic, Non-Acute Diagnosis and Treatment (6 percent of all visits)

- Anemia
- Asthma
- Bronchitis
- Dermatitis
- Fatigue
- Hypertension
- Obesity
- Vitamin deficiency
- Weight loss

Mental Health (16 percent of all visits)

- Individual, family, relationship counseling
- Consultations
- Crisis intervention
- Child abuse reports

Family Planning (19 percent of all visits)

- Counseling
- Provision of contraceptives

Reproductive Health (19 percent of all visits)

- Gynecological services
- Pregnancy tests

- Prenatal/postnatal care
- Sexually transmitted disease treatment and diagnosis

Health Education and Group Services

Classroom Presentations (75 percent of all services)

- First Aid
- Self-esteem/decision-making
- HIV/AIDS
- Nutrition
- Physical abuse
- Asthma
- Substance abuse
- Exercise
- Reproductive systems
- Contraception/abstinence
- Sexuality
- Sexually transmitted diseases
- Stress management
- Goal setting
- Drop out prevention
- Date rape
- Methods of communication
- Hypertension
- Personal hygiene

Special Programs (15 percent of all services)

- AIDS prevention
- Fitness
- Young men's peer group
- Prenatal care
- Parenting
- Young women's peer group

Community and School Outreach (10 percent of all services)

- Health fairs
- School council participation
- Feeder school presentations
- Teacher in-services
- Health center open houses
- Blood pressure screening day for parents
- Information booth at report card pickup

Requirements for Participation in Condom Availability

Parental consent is required, as students must be enrolled in the health center to receive condoms and parents sign a consent form upon enrollment. Counseling is required when students obtain contraceptives, including condoms.

Condoms and Counseling Availability

Condoms are available during all center hours. Counseling and condoms are provided by nurse practitioners, physicians, social workers and health educators.

Follow-Up Care

Both oral contraceptives and condoms are available on a limited basis, with an appointment, physical examination and psychosocial assessment required during a student's initial visit. Regular medical follow-up represents a standard component of the prevention model used in this program. When students visit the health center and request condoms, they must receive counseling at the initial as well as each subsequent visit regarding abstinence and the risks of sexual intercourse. When young women request oral contraceptives at the health center, they receive counseling about using condoms, in addition to oral contraceptives for protection against STDs, including HIV.

Number of Condoms Available Per Visit

A student requesting condoms may receive up to six during a visit.

Funding

Condom availability is a component of the preventive health model guiding each of the three adolescent health centers in the Ounce of Prevention Fund program. Funding for the health centers is provided by private foundation and public funds, including contributions from the Illinois Departments of Public Health and Public Aid and Medicaid reimbursements. Condoms and other contraceptives, however, are purchased with private funds only.

Components of Success

Those aspects which have enhanced the success of this intervention model, with its contraceptive availability component are:

- An ongoing commitment to community outreach, including continued involvement of local school boards and school councils.
- A strong emphasis on health education, including involvement in the school curriculum and other group and individual education services.
- The use of a prevention model specially designed to address high-risk behavior, unnecessary morbidity, low birth weight and too-early childbearing.

Notes

[1]Baltimore City Health Department, "Comprehensive School Health Services Program: Baltimore City School-Based Clinics History," revised December, 1991.

CHAPTER NINE
RESOURCE LIST

I. ADOLESCENT SEXUALITY

A. Organizations

The Alan Guttmacher Institute
111 5th Avenue
New York, NY 10003
(212) 254-5656

American College of Obstetricians & Gynecologists
Resource Center
409 12th Street, SW
Washington, DC 20024

American Social Health Association
P.O. Box 13827
Research Triangle Park, NC 27709
Herpes hotline: (919) 361-8488/AIDS hotline: (800) 342-2437
Spanish-speaking AIDS hotline: (800) 243-7889
STD hotline: (800) 227-8922/For the deaf: (800) 344-7432

Association of Reproductive Health Professionals
2401 Pennsylvania Avenue, NW
Suite 350
Washington, DC 20037-1718
(202) 466-3825

The Center for Population Options
1025 Vermont Avenue, NW, Suite 210
Washington, DC 20005
(202) 347-5700

National AIDS Information Clearinghouse
P.O. Box 6003
Rockville, MD 20850
(800) 458-5231

National Family Planning and Reproductive Health Association
122 C Street, NW
Suite 380
Washington, DC 20001
(202) 628-3535

National Organization for Adolescent Pregnancy and Parenting
4421A East-West Highway
Bethesda, MD 20814
(301) 913-0378

Planned Parenthood Federation of America
810 7th Avenue
New York, NY 10019
(212) 541-7800

Sex Information and Education Council of the U.S.
130 West 42nd Street
Suite 2500
New York, NY 10036
(212) 819-9770

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II. HIV/AIDS AND SEXUALITY EDUCATION

A. Organizations

AmFAR Education Department
733 3rd Avenue, 12th Floor
New York, NY 10017
(212) 682-7440

The Center for Population Options
1025 Vermont Avenue, NW,Suite 210
Washington, DC 20005
(202) 347-5700

Centers for Disease Control and Prevention
Division of Adolescent and School Health
Center for Chronic Disease Prevention and Health Promotion
1600 Clifton Road, NE
Atlanta, GA 30333
(404) 639-0848

Council of Chief State School Officers
1 Massachusetts Avenue, NW
Suite 700
Washington, DC 20001
(202) 408-5505

ETR Associates
P.O. Box 1830
Santa Cruz, CA 95061
(408) 438-4060

Gay Men's Health Crisis
129 West 20th Street
New York, NY 10011
(212) 807-6664

Home Economics Association
1555 King Street
5th Floor
Alexandria, VA 22314
(703) 706-4600

National Association of State Boards of Education
1012 Cameron Street
Alexandria, VA 22314
(703) 684-4000

National Education Association
Health Information Network
1201 16th Street, NW
Washington, DC 20036
(202) 822-7570

National Minority AIDS Council
300 I Street, NE
Suite 400
Washington, DC 20012
(202) 544-1076

National School Boards Association
1680 Duke Street
Alexandria, VA 22314
(703) 838-6722

Impact AIDS
25 Van Ness Avenue
Suite 660
San Francisco, CA 94102
(415) 864-5855

Sex Information and Education Council of the US
130 West 42nd Street
New York, NY 10036
(212) 819-9770

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III. SCHOOL CONDOM AVAILABILITY

A. Organizations

The Center for Population Options
School Condom Availability Campaign and Clearinghouse
1025 Vermont Avenue, NW
Suite 210
Washington, DC 20005
(202) 347-5700

New York City Public Schools
Expanded HIV/AIDS
Education Program and Condom Availability Program
131 Livingston Street
Brooklyn, NY 11201
(718) 935-5606

National Association of State Boards of Education
1012 Cameron Street
Alexandria, VA 22314
(703) 684-4000

National School Boards Association
1680 Duke Street
Alexandria, VA 22314
(703) 838-6722

Sex Information and Education Council of the U.S.
130 West 42nd Street
Suite 2500
New York, NY 10036
(212) 819-9770

U.S. Conference of Mayors/Local Health Officers
1620 I Street, NW
Washington, DC 20001

(202) 293-7330

B. Books and Reports

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IV. SCHOOL-BASED HEALTH CENTERS/HEALTH CARE SERVICE DELIVERY

A. Organizations

American Academy of Pediatrics
Division of Child & Adolescent Health
Task Force on School-Based Health Clinics
141 NW Point Boulevard
P.O. Box 927
Elk Grove Village, IL 60009-0927

The Center for Population Options
Support Center for School-Based Health Centers
1025 Vermont Avenue, NW
Suite 210
Washington, DC 20005
(202) 347-5700

Robert Wood Johnson Foundation
School-Based Health Care Program
Children's National Medical Center
111 Michigan Avenue, NW
Washington, DC 20010
(202) 745-2000

B. Books and Reports

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V. ADOLESCENT HEALTH

A. Organizations

American Medical Association
Department of Adolescent Health
515 North State Street
Chicago, IL 60610
(312) 464-4430

American Psychiatric Association
1400 K Street
Washington, DC 20005
(202) 682-6220

American Psychological Association
750 1st Street, NE
Washington, DC 20002
(202) 336-5500

American Public Health Association

1015 15th Street, NW
Washington, DC 20005
(202) 789-5600

American Red Cross
2025 E Street, NW
Washington, DC 20006
(202) 737-8300

American School Health Association
P.O. Box 708
Kent, Ohio 44240
(216) 678-1601

Centers for Disease Control and Prevention
Division of Adolescent and School Health
Center for Chronic Disease Prevention and Health Promotion
1600 Clifton Road, NE
Atlanta, GA 30333
(404) 639-0848

Children's Defense Fund
25 E Street, NW
Washington, DC 20001
(202) 628-8787

Child Welfare League of America
440 1st Street, NW
Suite 310
Washington, DC 20001
(202) 638-2952

National Association of School Nurses
Lamplighter Lane
P.O. Box 1300
Scarborough, ME 04074
(207) 883-2117

National Coalition of Advocates for Students
100 Boylston Street
Suite 737
Boston, MA 02116-4610
(617) 357-8507

National Coalition of Hispanic Health and Human Services Organizations (COSSHMO)
1501 16th Street, NW
Washington, DC 20036
(202) 387-5000

National Council of La Raza
810 First Street, NE
Suite 300
Washington, DC 20002
(202) 289-1380

National Institute of Child Health and Human Development (NICHD)
National Child Health Bureau
9000 Rockville Pike

Building 31, Room 2A32
Bethesda, MD 20892
(301) 496-5133

National Lesbian and Gay Health Foundation
P.O. Box 65472
Washington, DC 20035
(202) 797-3708

National Network of Runaway and Youth Services
1319 F Street, NW
Washington, DC 20004
(202) 783-7949

National Women's Health Network
1325 G Street, NW
Lower Level
Washington, DC 20005
(202) 347-1140

Society for Adolescent Medicine
19401 East 40 Highway
Suite 120
Independence, MO 64055
(816) 795-TEEN

US Conference of Mayors/Local Health Officers
1620 I Street, NW
Washington, DC 20001
(202) 293-7330

B. Books and Reports

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C. *Articles*

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VI. NEEDS ASSESSMENT & EVALUATION

A. *Organizations*

Academy for Educational Development
100 5th Avenue
New York, NY 10011
(212) 243-1110

The Center for Population Options
1025 Vermont Avenue, NW
Suite 210
Washington, DC 20005
(202) 347-5700

Centers for Disease Control and Prevention
Division of Adolescent and School Health
MS-K31
1600 Clifton Road, NE
Atlanta, GA 30333
(409) 639-0848

Child Trends, Inc.
2100 M Street, NW
Suite 610
Washington, DC 20037
(202) 223-6288

ETR Associates
P.O. Box 1830
Santa Cruz, CA 95061
(408) 438-4060

Education Development Center
55 Chapel Street
Newton, MA 02160
(617) 969-7100

National Center for Health Statistics
Technical Services Bureau

12 Davis Drive
P.O. Box 12214
Research Triangle Park, NC 27709
(919) 541-0985

B. Books and Reports

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VIII. CONDOM EFFICACY

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B. Articles

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IX. ADOLESCENT, SEXUAL AND REPRODUCTIVE HEALTH ADVOCACY ORGANIZATIONS

AIDS Action Council
1875 Connecticut Avenue, NW
Suite 700
Washington, DC 20009
(202) 986-1300

American Association of University Women
Program and Policy Department
1111 16th Street, NW
Washington, DC 20035
(202) 785-7770

American Civil Liberties Union
132 West 43rd Street
New York, NY 10036
(212) 944-9800

Catholics for a Free Choice
1436 U Street, NW
Suite 301
Washington, DC 20009
(202) 986-6093

Center for Reproductive Law & Policy
120 Wall Street
New York, NY 10005
(212) 514-5534

Gay Men's Health Crisis
129 West 20th Street
New York, NY 10011
(212) 807-6664

Girls, Inc.
30 East 33rd Street
New York, NY 10016
(212) 689-3700

Human Rights Campaign Fund
1012 14th Street, NW
Washington, DC 20005
(202) 628-4160

National Abortion Rights Action League
1156 15th Street, NW
Suite 700
Washington, DC 20005
(202) 973-1000

National Center for Youth Law

114 Sansome Street
Suite 900
San Francisco, CA 94104
(415) 543-3307

National Gay and Lesbian Task Force
1734 14th Street, NW
Washington, DC 20005
(202) 332-6483

National Organization for Women
1000 16th Street, NW, Suite 700
Washington, DC 20005
(202) 331-0066

National Women's Law Center
1616 P Street, NW
Suite 100
Washington, DC 20009
(202) 328-5160

People for the American Way
2000 M Street, NW
Washington, DC 20036
(202) 467-4999

Planned Parenthood Federation of America
810 7th Avenue
New York, NY 10019
(212) 541-7800

Religious Coalition for Abortion Rights
100 Maryland Avenue, NE
Washington, DC 20002
(202) 543-7032

United States Students Association
815 15th Street, NW
Suite 838
Washington, DC 20005
(202) 347-8772

Women's Legal Defense Fund
1875 Connecticut Avenue, NW
Suite 710
Washington, DC 20009
(202) 986-2600

Y.W.C.A.
725 Broadway
New York, NY 10003
(212) 614-2827

Zero Population Growth
1400 16th Street, NW
Suite 320
Washington, DC 20036
(202) 332-2200